HEALTHY BROOKLINE VOLUME XII

AGING AT HOME: A STUDY OF BROOKLINE'S 85 AND OLDER SENIORS

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HIGHLIGHTS

Health

63% requested information and/or services and were referred to social workers at the Brookline Council on Aging.

People most frequently wanted information about and/or services for transportation problems (24%), housing concerns (28%) and socialization (31%).

Over half of the respondents (52%) were not disabled, meaning they had no difficulties carrying out the common activities of daily living on their own without assistance; 42% were frail; and 6% were severely disabled. Men and women were equally likely to be severely disabled, but women were more likely than men to be in the frail category.

The three most frequently mentioned health problems that limited activities were: walking, hearing, and arthritis, mentioned by 50% to 60%.

The three activities of daily living that caused the most difficulties were: housework, shopping for groceries, and laundry, mentioned by 23% to 27%.

On the whole, respondents had excellent access to the health care system; most had seen a medical professional for a check-up or illness during the past year. The severely disabled and those with financial problems were less likely than others to have seen a dentist during the past year.

A little over one-third had fallen during the past year, and half of those who had fallen sustained injuries. Among those who sustained injuries, half had fallen inside their home.

58% engaged in a physical activity, such as walking, yoga, or gardening for at least half an hour 3 times a week; they were less likely to have fallen during the past year.

Mental Health

On the whole, people were positive about their lives: 86% enjoyed life and 83% were happy. 91% were either “very” or “somewhat satisfied” with their lives.

15% were depressed: 20% of the women and 3% of the men. 68% of those who were depressed did not seek help for their emotional problems during the past year.

Housing

22% lived in single family homes; 44% lived in multiple family residences; and 34% lived in senior housing. People living in single family homes tended to be married and were less likely to be disabled.

Most had smoke detectors. Only 42% had personal emergency call systems; people in senior housing were more likely than others to have home safety adaptations.

Transportation
42% were still driving; 70% were driving almost every day; and 62% of those who drive limited their driving because of weather, distance, etc..

14% had transportation problems: the frail or severely disabled, those who were depressed, and those with financial problems were more likely than others to mention transportation problems.

A little over one-fifth lacked familiarity with the H.E.L.P Escort program which is run by the Brookline Council on Aging, and 15% lacked familiarity with Springwell's Busy Bee transportation service.

Social Connections/ Social Support
On the whole, people seemed well-connected socially. Three-quarters had family living nearby; 3/5 talked to family, friends, or neighbors almost everyday; and over 90% had a confidant, someone they could talk to about problems or important decisions.

A little over one-third had a computer which they used to keep in touch with family and friends.

54% had a formal or informal check-up system, whereby someone checks up on them or they check up on someone else on a regular basis.

There was a large discrepancy between communication with relatives/ friends/ neighbors and participation in activities outside the home; 71% spoke to relatives, friends, or neighbors either in person or on the telephone 3 times a week or more, while 31% participated in social activities outside their home 3 times a week or more.

8% were still working; almost all voted in the November 2008 election; 17% were involved in a formal volunteer activity with an organization. This understates the amount of volunteering that occurs since some were involved in informal volunteering or helping activities with friends, relatives, or neighbors.

Most (84%) thought the amount of communication they had with relatives, friends, or neighbors was "enough," irrespective of the frequency of communication; 16% thought it was "not enough." 30% said they were "often" lonely. The severely disabled, those with a hearing impairment and those who were depressed were more likely than others to say communication was "not enough" and that they were "often" lonely.

Finances
88% were able to meet their current expenses and denied any financial problems. However, when asked about their most pressing concerns, 19% mentioned finances.

Recommendations

Access to Information
Communicate information more effectively not only to consumers but also to front-line professionals and employees who interact with seniors on a regular basis.

Social Engagement
Develop more opportunities for seniors to participate with others as community volunteers and/or in mutual-aid relationships within neighborhoods.

Provide more opportunities for seniors to participate in intellectual, social and cultural activities that provide greater intellectual stimulation and challenge.

Provide more opportunities for seniors to learn computer skills and enlist community volunteers with computer expertise to help seniors in their own homes with computer issues.

Publicize the importance of having check-up systems and provide opportunities for people to form their own buddy systems.

Transportation
Publicize alternative transportation options more widely.

Develop a centralized information source for information about transportation alternatives.

Train volunteers to help seniors fill out the various applications and forms that are needed when applying for transportation services.

Housing
Encourage the Brookline Town Meeting to revisit the issue of accessory dwelling units.

Continue to develop and publicize a list of companies offering routine home maintenance services.

Falls
Develop a volunteer program to assess environmental safety issues in the home to prevent falls.

Provide a clearinghouse of information about universal design and home modification.

Develop a protocol with Brookline Police and Fire Departments to notify BCOA if called to an elder's home more than once during the year because of falls.

Personal Emergency Response Systems
Front-line professionals and employees who provide services to seniors need to encourage them to have a personal emergency response system.

Physical Exercise
Publicize more widely the availability of home-based exercise offered by volunteers from Friendship Works.

Explore the possibility of holding exercise programs at different locations in the community (community rooms of apartment or condo buildings, local religious institutions, etc.).

Look into developing a post-hospital follow-up exercise program after in-home or rehabilitation center physical therapy has ended.

Hearing Loss
There is a need for more public education about hearing loss as well as the personal and home-based equipment that is available.

Agencies and professionals serving seniors should be on the alert for seniors with hearing impairment who do not use any devices to compensate for their hearing loss.

Depression
Medical and social service professionals need to be proactive in recognizing depression among the elderly and making recommendations for treatment.

Publicize the BCOA pharmacy consultation program as an additional resource (in addition to seeing their doctors) for seniors who have problems with their depression medication.

Look into some of the newer evidence-based programs that treat depression among seniors.

Publicize the availability of support groups for seniors who are sad and/or depressed.

Dental Care
Work with the Brookline Department of Public Health and the local dental schools to see if access to dental care can be improved for severely disabled and low income seniors.

Concerns about Health and Finances
Offer short-term support groups about end-of-life and aging concerns. Provide information and educational forums on financial issues and how to choose a financial planner.

Implementation of Research Results
Form an implementation committee to look over the recommendations; determine which have the highest priority and the greatest likelihood of success; develop plans to implement the recommendations.

Further Research
Further research needs to be conducted with public housing residents as well as residents who are non-English speakers.

1.0 EXECUTIVE SUMMARY

1.1 Introduction

The 85 and over population is the fastest growing population segment in the United States. Given this trend, communities need to better understand the socio-demographic, health, housing, transportation, social, and financial characteristics of this group to identify gaps in services and plan ahead for the future. Under the auspices of the Brookline Council on Aging and funded by a grant from the Brookline Community Foundation, an action-research study of this group was conducted. Administrative support was also given by the Brookline Department of Public Health and New England Survey Systems. The project had four goals: (1) describe the characteristics of the 85 and older population, (2) conduct a needs assessment study both to learn about unmet health and social service needs and to refer people with identified needs to social workers at the Brookline Council on Aging, (3) provide respondents with information about resources and services available in the local area, and (4) develop recommendations based on the data which could be used as a blueprint for further action.

1.2 Methods

An Advisory Committee composed of representatives from the various agencies and programs that serve Brookline seniors was formed to oversee the research project. Respondents were randomly selected with the exception of Brookline public housing residents who were all invited to participate. Trained volunteers (20) used a structured questionnaire and collected data by in-person interviews or telephone calls. Data were collected from 223 respondents, yielding a 51% response rate. Only people who were 85 and older, who lived independently, who could speak and understand English, and who had no hearing or memory impairment were included in the study. Respondents were predominantly in the younger age 85-89 age group, female, well-educated, Jewish, and had lived in Brookline for more than 10 years. It is common that people who respond to surveys are likely to be in better physical and mental health and in better financial circumstances than people who refuse. Thus, it is likely that the sample has biases.

1.3 Health

<u>Health Profile</u>

- The health profile of this group was fairly positive. Almost 70 percent rated their health as “excellent,” “very good,” or “good;” less than one-third rated their health as “fair” or “poor.”
- One-third indicated their health problems did not limit their activities either inside or outside their homes; two-thirds indicated there were some activity limitations.
- The three most frequently mentioned health problems that limited activities were walking, hearing, and arthritis (50% to 60% mentioned these problems).

Activities of Daily Living

- Over half (52%) had no difficulties carrying out the common activities of daily living on their own without assistance.[1] The remainder, 48 percent, had difficulties; 42 percent were frail and 6 percent were severely disabled.[2]
- Level of disability increased along with age; 5 percent of those aged 85-89, 9 percent of those aged 90-94, and 33 percent of those aged 95 and over were severely disabled.
- There were no differences between men and women in the severely disabled category; more women than men tended to be in the frail category (47% vs. 29%) and more men than women were in the no disability category (62% vs. 47%).
- The three activities of daily living causing the most difficulties were: housework (27%), shopping for groceries (23%), and doing laundry (23%).
- Instead of finding a pattern of people having increased difficulty with self-care as they got older, the major differences occurred between the two younger age groups (those in the 85-89 and the 90-94 groups) and the 95 and older group.

Assistance with Activities of Daily Living

- Thirty-eight percent were receiving some assistance with activities of daily living.
- Among the disabled (includes the severely disabled and the frail), 79 percent were receiving some help.
- The percentage receiving help increased as the level of disability and age increased. Seventy-seven percent of the frail and 93 percent of the severely disabled were receiving help. Thirty-four percent of those 85-89, 43 percent of those 90-94 and 61 percent of those 95 and over were receiving help.

Falls

- A little over a third had fallen during the past year. Over half of those who had fallen were injured, and over half of them fell inside their homes.
- Fifty percent of all respondents used walking aids. People who had fallen were more likely to use walking aids than those who had not fallen (66% vs. 41%). The data do not indicate whether people were using walking aids at the time of their fall or whether they started using them after their fall.
- The use of walking aids increased as age increased.

Access to Health Care

- On the whole, respondents had excellent access to the health care system. Almost all had seen a medical professional (doctor, nurse practitioner, or physician's assistant) for a check-up or because of illness during the past year.
- Over 4/5 had a flu shot; over 4/5 had seen an ophthalmologist or optometrist; and approximately 3/4 had seen a dentist during the past year.
- The disabled and those with financial problems were somewhat less likely to have seen a dentist during the past year. Forty-three percent of the severely disabled

[1] Activities involved in self-care (e.g., bathing, dressing, etc.) and activities required for independent living (e.g., shopping, housework, meal preparation, etc)..

[2] The frail had difficulty with at least two self-care activities and one or more activities required for independent living, and the severely disabled had difficulties with 3 or more self-care activities. This categorization is based on the 2006 Urban Institute report by Johnson and Wiener entitled *A Profile of Frail Older Americans and Their Caregivers*.

and 66 percent of the frail had seen a dentist during the past year. Sixty-two percent of those with financial problems and 78% of those without financial problems had seen a dentist during the past year.

Medications

- Most were taking medications on a regular basis; 8 people used no medications.
- Twenty-nine percent had concerns about their medications; individuals with higher levels of education were more likely than others to have concerns.
- The two most commonly mentioned concerns were: forgetting to take medications and worries about side effects or drug interactions.
- People who were depressed were more likely than others to worry about whether they were taking their medications correctly.

Meal Preparation and Nutrition Concerns

- Seventeen percent regularly had lunch or dinner in a group setting, such as a senior housing residence or the Brookline Senior Center (lunch only); 9 percent received Meals on Wheels.
- Age was related to eating meals in a group setting; as age increased the percentage of people having meals in a group setting increased (e.g., lunch at the Brookline Senior Center or meals at a senior residence).
- Disability was related to receiving Meals on Wheels.
- Thirty-seven percent had nutrition concerns. Having meals prepared by an outside source (eating meals in a group setting or receiving Meals on Wheels) was related to having some nutrition concerns.
- Losing weight without trying, gaining weight, and eating poorly because of decreased appetite were the most commonly-mentioned nutrition problems.
- The severely disabled and those with financial problems were more likely than others to have nutrition concerns.

Physical Activity

- Fifty-eight percent engaged in a physical activity, such as walking, yoga, or gardening for at least half an hour three times or more a week.
- People with no disability were more likely to engage in physical activity than people who were frail or severely disabled.
- Age and sex were unrelated to physical activity.
- Individuals who engaged in physical activity were less likely than others to have fallen during the past year (27% vs. 45%).

Activities of Daily Living (ADL) and Health Service Needs

- Eight percent of those who were not receiving assistance with activities of daily living said they needed help with ADLs.
- Eleven percent indicated a need for health information or services.
- People who were depressed or disabled were more likely than others to need information or services in relation to their ADLs or their health.

Most Pressing Concerns

- When asked about their most pressing concerns, 23 percent mentioned health. They had concerns about: specific health conditions, their general health (fear of health decline, etc.), becoming a burden on others, and the unpredictability of the future.

1.4 Mental Health

Mood

- On the whole, people were positive about their lives: 86 percent enjoyed life and 83 percent were happy. Even so, there were some negative feelings: 41 percent "often" felt sad, 30 percent "often" felt lonely, and 21 percent "often" felt everything was an effort.

Overall Satisfaction with Life

- Ninety-one percent were either "very" or "somewhat satisfied;" only 9 percent were "not very" or "not at all satisfied." The high percentage of elderly indicating satisfaction is confirmed by research about seniors.
- Seniors seem to view their lives through different lenses than younger people. For example, someone with inoperable cancer said *"I'm very satisfied with life in spite of my diagnosis."*

Depression

- Depression was assessed by using a scale employed by two nationally-known health studies.
- Fifteen percent were depressed. Depression was more frequent among women than among men; 20 percent of women compared to 3 percent of the men were depressed.
- People who considered their health was "fair" or "poor," who were frail or severely disabled, who had a hearing impairment that limited their activities, who lived alone, who lived in senior residences, or who had financial problems were more likely than others to be depressed.
- Those having difficulties with housework and shopping tended to feel more depressed than those who did not have difficulties with these tasks.

Use of Resources for Emotional Problems

- Fourteen percent sought help for emotional problems during the past year.
- People most frequently sought the help of psychiatrists, psychologists, social workers, and physicians.
- Thirty-two percent of people who were depressed sought help; thus, 68 percent of those who were depressed did not seek help.
- Sex and level of education were unrelated to seeking help. However, people living in senior housing residences were somewhat more likely to seek help than others, perhaps because these services were available on the premises of some senior residences.

1.5 Housing

General Housing Patterns

- The majority (78%) had lived in Brookline for more than 10 years; 15 percent had lived here for 5 years or less.
- Forty-five percent were home owners; 55 percent, renters.
- Home-owners were more likely to be men, to be in the younger 85-89 age group, and to be in better health than those who were renters.
- Twenty-two percent lived in single family homes; 44 percent lived in multiple family residences (2-3 family homes, apartments, and condos that were not senior housing); and 34 percent lived in senior housing residences.
- Twelve percent were thinking about moving: 26 percent of single family home owners, 13 percent who lived in multiple family residences, and 4% who lived in senior residences were thinking about moving.
- Fifty-eight percent lived alone. Among those living with others, most lived with their spouse.
- There were differences in patterns by housing type. Compared to those who lived in multiple family residences or single family homes, respondents in senior housing were more likely to be older, unmarried, frail, living alone, and living in Brookline for 10 years or less. Respondents in single family homes were more likely to be in the younger 85-89 age group, married, non-disabled, and living in Brookline for more than 10 years,

Home Safety Adaptations

- Almost all respondents had smoke detectors; three-quarters had basic home safety features like grab bars around toilet, a raised toilet seat, a seat in the shower or tub, etc.; three-quarters had carbon monoxide detectors.
- The presence of basic home safety features increased along with the level of disability.
- Forty-two percent had personal emergency call systems. These were more prevalent among women, people in the oldest 95 and older group, the severely disabled, and those living alone.
- Individuals living in senior residences were more likely than those living in other types of housing (multiple family residences or single family homes) to have personal emergency response systems and home safety features.

Housing-related Service Needs and Pressing Concerns

- Twenty-eight percent needed information or services related to their housing concerns.
- The three most frequently mentioned needs were for: information about housing alternatives, emergency response systems, and help with yard work and snow shoveling.
- Seventeen people had pressing concerns about housing: home maintenance and home safety adaptations, moving, building security, and feeling socially isolated in their living environment.

1.6 Transportation

Driving Patterns

- Forty-one percent of the respondents still drive.
- Among those who drive, 70 percent drive every day; 62 percent of those who drive engage in some type of self-regulation (not driving in bad weather, on highways, or long distances, etc.).
- Men, those who are in better health and have no disabilities, those with better mental health, and those living in single or multiple family non-senior residences are more likely than others to drive.
- People who are unmarried, who live alone, who live in single family or multiple family residences are more likely than others to drive every day.

Other Transportation Modes

- Aside from driving, family, friends, and neighbors provide the most frequent type of transportation.
- Public transportation was more frequently used by men, those without a disability, and those without a walking problem. The "Ride" was more frequently used by women and those living in senior residences.
- People lacked familiarity with certain transportation options; 22 percent lacked knowledge of the H.E.L.P escort program which is run by the Brookline Council on Aging, and 14 percent lacked knowledge about Springwell's Busy Bee transportation.

Transportation Problems

- Twelve percent had problems finding escorts and 6 percent mentioned other types of transportation problems. In all 14 percent had transportation problems.
- People who perceived their health to be "fair" or "poor," who were frail or severely disabled, and who were depressed were more likely than others to report transportation problems.

Transportation Needs and Pressing Concerns

- Twenty-four percent had transportation needs. The two most frequently mentioned needs were: information about transportation alternatives and information about the application process for transportation services.
- People with transportation needs were more likely than others to be in poorer health, to be frail or severely disabled, and to have walking problems.
- Nineteen percent said transportation was a pressing concern. The concerns included: difficulty finding escorts, difficulty getting out in bad weather, lack of knowledge about transportation options, the cost of transportation services, problems with specific transportation modes, lack of flexibility of transportation (need 24 hr. notice), specific neighborhood-related problems, problems caused by disability, and difficulty finding transportation to specific locations.

1.7 Social Functioning

Behavioral Characteristics

- The majority of respondents were well-integrated socially.
- Three-quarters had family living nearby (defined as less than 30 minutes away).
- Three-fifths talked with family members, friends, or neighbors either in person or by telephone almost every day. (Frequency of communication was unrelated to any independent variables used in this analysis).
- Ninety-four percent had a confidant, someone to talk to about problems or important decisions; 90 percent mentioned a relative as a confidant; 6 percent reported that their only confidants were professionals or volunteers, rather than relatives, friends, or neighbors.
- Over half (54%) had some type of formal or informal check-up system. Thus, 46 percent had no check-up system.
- Level of disability was related to having a check-up system: 85 percent of the severely disabled, 60 percent of the frail, and 46 percent of those with no disability had a check-up system.
- Those who had frequent communication with people (spoke to people 3 times a week or more), and those who had a relative as a confidant were more likely than others to have check-up systems.
- Thirty-five percent had a computer which they used to keep in touch with family and friends. Men, those in better health, and those with a higher level of education were more likely than others to use computers.
- While communication with people on the telephone or in person tended to be quite frequent, social activity participation outside the home was less frequent. Seventy-one percent speak to relatives, friends or neighbors three times a week or more, while 31 percent participate in social activities outside their home three times a week or more.
- People who were socially active (participated in activities 3 times a week or more) tended to be unmarried, to have no disability, to have good mental health, and to drive.
- There was no relationship between frequency of communication and frequency of activity participation.
- Nineteen people (9%) had caretaking responsibilities; 10 were caring for their spouse in their home.

Selected Activities

- Twenty-two percent participated in Brookline Senior Center activities during the past month.
- Almost half receive the Brookline Senior Center newsletter.
- Eight percent (17 people) were still working.
- Nearly all (93%) voted in the November ’08 presidential election.
- Seventeen percent participated in formal volunteer activities for an organization; they tended to be in better physical and mental health and tended to have higher levels of education than those who did not volunteer. This percentage understates the amount of volunteering that takes place, since people do informal volunteering (e.g., helping neighbors, relatives, or friends).

Subjective Feelings

- The majority of people (84%) thought the amount of communication they had with relatives, friends, and neighbors was "enough," irrespective of their actual frequency of communication.
- People who were severely disabled, who had a hearing impairment, and who were depressed were more likely than others to say communication was "not enough."
- Thirty percent said they "often" felt lonely.
- People who "often" felt lonely tended to have certain demographic characteristics: (female, 95 and older, not presently married, lower levels of education, living in a senior residence); certain health and mental health characteristics (frail or severely disabled, depressed); and certain structural/ behavioral characteristics (no family nearby, no family member who was a confident, and did not use computers to stay in touch with people).

Socialization Needs and Pressing Concerns

- Thirty-one percent wanted to receive information about social activities such as Senior Center programs, volunteer activities, educational programs, or activities at places of worship and/or wanted to receive information about activities that would increase their social contact with others. Thirty-six percent wanted to receive a copy of the Senior Center newsletter.
- The most frequently-mentioned pressing social and family concerns were: lack of companionship, lack of opportunities to engage with others in social activities, and concerns about the health of other family members.

1.8 Finances

- Eighty-eight percent said they were able to meet their current expenses and had no financial problems, while 12 percent said they could barely meet their expenses.
- Among those citing financial problems, the 4 most frequently-mentioned problems were the cost of: health care/ health insurance/dental care, medications, heat, and home health aides, mentioned by 6-7 respondents.
- People with financial problems tended to be: 95 and over, unmarried, in "fair" or "poor" health, "often" lonely, depressed, and living in a senior residence.

Financial-Related Service Needs and Pressing Concerns

- People with financial problems were no more likely to indicate a need for information or services than people without financial problems.
- Eight people mentioned they would like to speak to someone about their financial problems.
- Nineteen percent (42 people) mentioned financial issues as their most pressing concern. The issues included: meeting basic needs (condo assessments, home repairs, property taxes, heating costs, cost of personal home care assistance, ambulance costs, medical bills, food bills); concerns about their ability to pay for anticipated future expenses; the need to economize even though they were just getting by; concerns about their need to receive financial help from children; worries about whether they will outlive their expenses; the need to speak to a

financial planner; concerns about the economy; and concerns about their children's financial circumstances.

1.9 Referrals and Need for Services

- Almost two-thirds (63%) requested information and/or services and were referred to social workers at the BCOA.
- Between 24 and 31 percent indicated a need for information and/or services in the areas of socialization, housing, and transportation.
- The data as a whole (both responses to structured as well as open-ended questions) indicated that people were unaware of a number of programs and services and/or had difficulties reaching out for help.

2.0 INTRODUCTION

Americans' life expectancy has dramatically increased in the past decade due primarily to improved prevention and education about lifestyle choices and improved medical technology and medical care. The U.S. Census Bureau's national population estimates indicate that the 85+ population is the fastest growing age group in the country. Between 1990 and 2000, the 85+ population grew by 38 percent from 3.1 to 4.2 million.[3] Between 2000 and 2006, the number jumped by 25 percent, from 4.2 to 5.3 million. It is predicted that the size of this age group will reach 9.6 million in 2030 as the first members of the baby boom generation (those born between 1946 and 1964) reach 85+ and to 21 million in 2050 as the last members reach 85+.[4] If life expectancy also improves, as is predicted, these numbers will be even higher.

This growth in the size of the 85+ population means that more people will experience an expanded period of chronic health-related issues and community and health service providers will see an upsurge in the need for social and health-related services. Not surprisingly, the 85+ group has the highest rate of disabilities (sensory impairment, physical disabilities, mental disabilities, self-care issues, and difficulties going outside the home) and chronic illnesses. However, research has also shown that this age group is quite diverse, and some have been able to maintain reasonably good health and remain active in the community. Thus, services for the 85+ population must be available to meet the needs of people who have differing levels of functioning and abilities.

Although a stereotype of older people is that many wish to move to a warmer climate, studies have shown that this is not true.[5] Most want to remain in their current homes, or at least, stay in their local communities. Therefore, communities need to gather data that will provide information about the current living situation and service needs of this group in order to plan ahead for the future so this age group can remain in the community as long as possible and be safe, supported, engaged, and adequately cared for.

GOALS

The goals of this study were:

(1) To describe the characteristics of the 85+ population in key areas of their lives: health, mental health, housing, transportation, social functioning, finances, and service needs.

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[3] Lisa Hefzel and Annetta Smith, *The 65 Years and Over Population: 2000*, The Census 2000 Brief Series, <http://www.nationalatlas.gov/articles/people/a_age65pop.html> .

[4] U.S. Bureau of the Census. *Older Americans 2008: Key Indicators of Wellbeing*. <http://www.AgingStats.gov., Table 1a>.

[5] Bayer & Harper, *Fixing to Stay: A National Survey of Housing and Home Modification Issues*. (Washington, D.C: AARP, 2000) indicated that 90% of people who are over 65 would like to remain in their current home as long as they can. From Frank G. Caro and Jan E. Mutchler , *Seniors in Public Housing*, p. 3 (Gerontology Institute, University of Massachusetts, Boston, 2003).

Since the 85+ population is diverse, this study examined each of the above key areas in relation to a number of variables such as age, sex, marital status, living group arrangement, and health to understand the underlying patterns.

(2) To conduct a needs assessment to determine unmet social service and health needs and to make referrals to the Brookline Council on Aging (BCOA) as appropriate.

If respondents and/or interviewers identified unmet social service or health needs, interviewers referred them to Brookline Council on Aging social workers who conducted their own assessments, provided information, and made referrals to appropriate programs. Since a personal interview (whether in-person or by telephone) was the major data collection approach, interviewers were able to make connections with homebound and isolated elderly and refer them for services if needed.

(3) To inform people about the services that are provided by community health and social service providers.

All respondents received a copy of the Brookline Council on Aging (BCOA) Elder Resource Guide, vol. 5, a compendium of information about a wide range of services for the elderly.

(4) To develop a set of recommendations that the Brookline Council on Aging (BCOA) and other community health and social service providers can use in their efforts to strengthen services and form an implementation committee that will prioritize the recommendations and develop plans for implementing those that are most feasible.

In designing this study, we tried to develop a set of monitoring tools and methods that could be used on a semi-regular basis (approximately every 5 to 10 years) to assess changes over time since the characteristics of this population are ever-changing.

3.0 METHODS

Brookline Community Foundation Grant
Based on the projection of increased need for health and social services for the elderly population, the Brookline Council on Aging (BCOA) applied for and received a grant from the Brookline Community Foundation to conduct a study of Brookline's 85+ population.

Advisory Committee
During the summer of 2008, the Director of the BCOA invited representatives from community agencies and town departments that provide services to elderly Brookline residents to join an Advisory Committee that would oversee the study. The committee included representatives from the Brookline Department of Public Health, the Brookline Housing Authority, Springwell, the Brookline Community Mental Health Center, the Visiting Nurses Association of Boston, Jewish Family and Children's Services, as well as several professionals with expertise in the area of elderly services. We wanted the Advisory Committee to function as a sounding board for research ideas and to monitor the research process. The Advisory Committee met several times during the course of the project, and we solicited their feedback on the questionnaire. Members were kept up-to-date with a number of progress reports and were given copies of the various letters and forms used in the study.

Survey Staff
The Brookline Department of Public Health and the Brookline Council on Aging provided the principal investigator with administrative assistance. During the course of the project, 3 public health interns helped with survey administration. The Brookline Council on Aging (BCOA) provided 21 volunteers: 17 BCOA volunteers and 3 social work interns conducted the interviews; one additional BCOA volunteer helped edit the returned questionnaires.

Survey Development
The principal investigator met individually with members of the Advisory Committee and held a focus group with seniors who were 85 and over to solicit suggestions for the questionnaire. In addition, other local and national surveys about this age group were examined. The questionnaire underwent a number of revisions based on feedback from the Advisory Committee, the Director and staff of the BCOA, the volunteer interviewers, and as a result of pilot tests which the principal investigator and volunteer interviewers conducted with volunteer interviewees whose names were provided by the BCOA.

Criteria for Inclusion in the Study
This was a study of independently-living residents, so people in assisted living or nursing home residences were excluded from the study population. Also, respondents needed to be healthy enough, both physically and mentally, to answer questions. Thus, people with serious hearing or memory problems who were unable to answer the questions easily were excluded. Proxies could not be used and people were excluded if interviewers encountered situations where a third person was present and the respondent relied on this person to answer questions.

Survey Description

The questionnaire was primarily composed of structured questions along with few open-ended questions. The interview was divided into three parts. Part 1 contained the interview cover sheet and interviewer's observations. This form, which the interviewer filled out after the interview, contained descriptive information about the respondent – name, date, type of housing, whether the respondent had any type of condition (mental or physical problem or language problem) that interfered with the interview, whether anyone else was present, and whether this interfered with the interview. In addition, it asked for information about the interview itself – length of time of interview, interview location, type of interview (telephone or in-person) and whether the interviewer encountered any difficulties during the course of the interview. Part 2 included questions about health, mental health housing, transportation, social support, community activities, finances, and social demographic characteristics. Part 3, the case-finding needs assessment section of the interview, asked respondents whether there were any services or information that they needed. Space was also provided for interviewers' observations -- whether any urgent concerns were noticed that required immediate attention and whether the respondent had needs that s/he did not identify. New England Survey Systems printed the interviews in a booklet form that was easy for interviewers to administer and that could be machine scanned. (See Appendix A for copies of the interview forms.)

Recruitment and Training of Volunteer Interviewers

During the fall of 2008, interviewers were recruited by notices in the BCOA newsletter and the Brookline Tab as well as through word of mouth. Letters were also sent to volunteer members of Brookline's Medical Reserve Corps (MRC) and Community Emergency Response Teams (CERT). Some interviewers had previously participated in BCOA programs while others were new to the BCOA. All prospective interviewers were interviewed either by the Director of the BCOA or the principal investigator. Interviewers came from a variety of backgrounds -education, social work, psychology. health, and gerontology; a few had survey research experience.

Starting in November, 2008, there were monthly volunteer group meetings. In addition to receiving copies of the questionnaire drafts and the final questionnaires, interviewers received a training notebook containing the forms and letters pertaining to the study. Over time, some issues required clarification and updates were added to the notebook.

The notebook contained the following:

- Grant proposal
- Introductory letter sent to respondents (see Appendix B)
- Letter to respondents with unlisted telephone numbers
- A simple description of the study; a list of questions people might ask about the study; and answers which interviewers could give.
- A training guide that discussed survey research procedures, including the importance of informed consent, a discussion of confidentiality vs. anonymity, how to begin the interview, and how to conduct the interview, etc.
- A list of common reasons for refusal and how to handle these types of responses
- Housing information – a description of the different types of senior housing residences that are found in Brookline

- Telephone Contact Form—a form that interviewers filled out for each respondent to track the outcome of each interaction (e.g., agreed to interview, refused, wrong number, etc.)
- Case-finding/referral guidelines – a description of each level of service need from Level 1- Urgent (requires immediate assistance) to Level 4- Routine (i.e., needs information about transportation. (See Appendix C)
- Updated procedures -- issues that required clarification
- Thank you letter to respondents

The initial training meetings introduced the project, the questionnaire, the methodology of survey research interviewing, and the case-finding and referral procedures. In March, 2009, interviewers were asked to conduct five pilot-test interviews. In April, 2009 the full-blown study began and interviewers received their regular assignments. Assignments were tailored depending upon whether interviewers wished to conduct telephone or in-person interviews. If interviewers wished to conduct in-person interviews in a particular geographic location, interviews also were tailored geographically. Once interviewing began, meetings were devoted to questions, concerns, and trouble-shooting. To insure quality control, completed interviews were edited by the principal investigator and another project volunteer. If there were inconsistencies in the way interviewers handled questions, these issues were discussed at a monthly meeting. If particular interviewers were not filling out the forms correctly, we discussed proper procedures with them. During the summer of 2009, guest speakers were invited to talk about issues concerning the elderly since less time was needed for trouble-shooting. Detailed notes were taken at each meeting and distributed electronically to everyone so those unable to attend could remain fully informed.

At the time the pilot interviews began, there were 17 volunteer interviewers and one volunteer who assisted with administrative tasks. By the time the interviews ended, there were 12 volunteer interviewers, as well as 3 social work intern interviewers who assisted with the public housing interviews. Interviewer attrition occurred due to changes in jobs or residences, travel, illness, or family problems. In several cases, interviewers decided to pursue other BCOA volunteer opportunities.

Use of the 2008 Town Census File and Random Sample Selection

The Brookline Information Technology Department provided the project with an electronic data file from the 2008 town census. The 2009 census file was unavailable prior to our April 2009 interview start date. The 2008 file contained the names, birthdates, and addresses of 1541 residents aged 85 and older who returned the 2008 town census form. Upon examining the file, we realized that residents of an assisted living residence were included; their names were excluded from the file, leaving a total of 1490 residents. People for whom English was not the first language were likely underrepresented in the data file since only those who vote are included in the town census. Pilot test interviews were completed in March 2009, and study interviews began in April. One-third of the residents from the data file were randomly selected, and they formed Group 1. When assignments from the Group 1 list were completed, half of the names on the unassigned list were randomly selected and these people formed Group 2. The remaining people on the list formed Group 3.

Survey Administration and Procedures

Members of the Brookline Police Department were advised about the study in event residents called them with concerns about the legitimacy of the interviews. Introductory letters which introduced the study and described the confidentiality procedures were mailed to all 1490 names on the 2008 Town Census. Approximately 13 percent were returned indicating that residents were no longer living at that address. After we had completed the Group 1 list, a second introductory letter was mailed people in Group 2 in case people did not remember the earlier letter. Letters were also mailed to residents with unlisted telephone numbers to ask them to give us their telephone numbers so we could invite them to participate. A few people did call to offer their telephone numbers.

Interviews were administered both in person and by telephone depending upon what worked best for the respondent and the interviewer. Forty percent were telephone interviews and 60 percent were in-person interviews. Although most of the in-person interviews were administered in respondents' homes, some took place at the Brookline Senior Center or in community rooms at senior residences**.**

Location of Interview	
Telephone	40%
Respondent's home	47%
Senior Center	5%
Center Communities	3%
Public Housing site	5%
Other	<1%

Interviewers contacted respondents by telephone to invite them to participate and gave them an overview of the study. If they agreed to be interviewed, a time was set for the interview. Most interviews took place in one session; ten took place over two sessions. The average length of time for a telephone interview was 44 minutes, while the average length of time for an in-person interview was 63 minutes. All respondents received a "thank-you" gift bag with items, such as a refrigerator magnet with the BCOA phone number, as well as the BCOA Elder Resource Guide, vol. 5. Interviewers also sent respondents a thank-you note.

The majority of interviews (218) took place during a seven month period, from April to October, 2009, which averaged to approximately 30 interview completions a month. When 218 interviews had been completed, and the Group 2 list had been completed, we considered calling a halt to the interviews. However, we decided to carry on a bit longer to increase the number of public housing interviews since only 9 had been completed. Introductory letters were mailed to all 85 and older public housing residents who had not been interviewed. Three BCOA social work student interns and four experienced volunteer interviewers contacted public housing residents who had not been interviewed. Residents who had previously refused interviews were approached as well as those who had not yet been approached. By January, 2010, only five additional public housing

interviews had been completed, yielding a total of 223 interview completions. Our experienced volunteer interviewers reported that it was more difficult to encourage these residents to participate than it had been to encourage non-public housing residents. Whether or not residents agreed to be interviewed, each public housing resident who was contacted received the BCOA Elder Resource Guide, vol 5.

Interview Response Rate

There were a variety of reasons for non-response:

- People were no longer living at the listed addresses because of death, institutionalization, or a move to some other locale.
- Some had unlisted telephone numbers or their telephones were out of order.
- A number of people could not be reached even though interviewers tried calling at least 4 or 5 times on different days and different times of the day. After five unsuccessful tries, interviewers were told to contact others on their list.
- There were a variety of other reasons for non-response, such as reluctance to be interviewed, language issues, dementia or confusion, illness, and hearing impairment.

Response Rate		
Original sample size		1490
Unassigned cases (interviewing ended before people were contacted)	503	
Sample size minus unassigned		987
Non-respondents excluded from sample:		549
illness	26	
not reachable by phone	227	
competency issues	26	
letters returned	237	
deceased	19	
moved	10	
younger than 85	4	
Eligible sample after subtracting non-respondents and unassigned		**438**
Interview completions		223
Refusals		171
Unaccounted-for cases – contact made; reasons for non-response are unknown		44
Responses rate (interview completions divided by eligible sample)		**51%**

Case-Finding and Referral Procedures

Interviewers followed a protocol developed by the BCOA Director which defined needs by level. There were four levels (See Appendix C). Level 1 was the most urgent and required immediate attention, and level 4 was the least urgent. Most of the needs identified were of the level 4 non-urgent variety. Urgent issues were brought to the

prompt attention of a BCOA social worker. In two instances, both having to do with depression, interviewers quickly referred these people to a BCOA social worker.

Sixty-three percent were referred to the BCOA for services. When respondents had service needs and gave permission for a BCOA social worker to contact them, interviewers noted the service needs on a case-finding form; the identified needs were compiled in reports and the Director of the BCOA assigned staff to follow-up. If respondents did not wish to be referred to the BCOA, written information was mailed. At times, interviewers identified issues which they felt required attention even though the respondents did not identify them as needing attention; these issues were also brought to the attention of the Director of the BCOA.

Data Analysis and Method of Presentation

New England Survey Systems scanned the interviews which insured accuracy and speed and saved us the cost of hiring staff to key-in data. The data were analyzed using SPSS. The analytic method was two-fold: (1) describe the characteristics of this group in the principal areas of their lives: health, mental health, housing, transportation, social functioning, finances, and service needs, and (2) examine the variables associated with patterns in these areas, such as age, sex, living group type, etc.. The analysis is primarily descriptive and relies on the cross-tabulation of two variables, an independent variable and a dependent variable; a series of independent variables was examined in relation to a series of dependent variables specific to the particular area under examination.

The core independent variables which were consistently examined in relation to the data were the basic social demographic variables of age, sex, current marital status. As each content area was examined, we added new independent variables. In other words, the number of independent variables increased as we analyzed each new content area. For example, when we examined health data, we aggregated some data and developed an index of disability status in addition to using age, sex, and marital status. When we analyzed the mental health variables, we again aggregated some data and developed an index of depression. Thus, when we analyzed housing, transportation, social functioning, and social needs, we were able to use disability status and depression as independent variables as well as other independent variables from each content area under consideration. In the case of disability status and the index of depression, we drew upon scales and indices developed by other researchers and cited the appropriate sources in our text.

The major independent variables used in the analysis included:

- Age
- Sex
- Current marital status
- Self-reported health status
- Disability status
- ADL Index (Activities of Daily Living)
- IADL Index (Instrumental Activities of Daily Living)
- Depression
- Living group type – living alone or with others

- Residence type – senior housing, multiple family residence (2-3 family and apartment or condo), and single family house
- Whether respondent drives
- Frequency of communication with relatives, friends, neighbors
- Frequency of activity participation
- Loneliness
- Perceived adequacy of social contact
- Financial problems

Depending on the area under consideration, a variable might be used as an independent or a dependent variable. For instance, in the mental health section, depression was a dependent variable since we wanted to see the patterns associated with depression, while in other sections it was used as an independent variable to see whether the areas under consideration were associated with depression.

Since the level of data collected is nominal or ordinal, we used non-parametric statistical tests (Chi-square Test and Fisher's Exact Test) to test for significant differences and relationships. The level of significance for these tests was set at the .05 level. In a study with a large number of variables and many cross-tabulations, a number of significant relationships may occur by chance. If relationships lacked conceptual clarity, we did not report this data. However, in a few instances, even though there was no statistical significance, we reported on these relationships if the findings were in the direction of significance (defined as $p<.10$) so as not to screen out meaningful findings on statistical grounds alone. It is also important to note that when a statistical relationship is reported, it does not denote a causal relationship; it indicates that there is a statistical association that was unlikely to occur by chance.

Limitations of the Study

With the exception of the effort made to interview one hundred percent of the public housing residents, we randomly chose residents to interview. However, since we encountered a number of refusals, we cannot say that our sample is representative of all independently-living Brookline residents in the 85 and older age group, so caution needs to be exercised in generalizing beyond this particular study population. People with poorer physical or mental health or people in lower socio-economic groups are less likely to participate than others, so the sample is probably biased in the direction of people who are better off physically, emotionally, and financially.

Social Demographic Characteristics of the Sample

The majority of respondents (over 60%) were female; aged 85-89; Jewish; had some college education/ bachelor's degree/ professional training; had children; were born in the U.S.; and lived in Brookline for 10 years or more. (See Appendix D1 and D2 for comparisons between 85+ sample and Census 2000 data and Brookline data [2006-2008]).

SOCIAL DEMOGRAPHIC CHARACTERISTICS (N=223)		
	N	%
SEX		
Female	158	71%
Male	65	29%
Total	*223*	
MARITAL STATUS		
Married	58	26%
Widowed	125	56%
Divorced/Separated	13	6%
Partner	3	1%
Never Married	24	11%
Total	*223*	
AGE		
85-89	151	68%
90-94	54	24%
95 and over	18	8%
Total	*223*	
EDUCATION		
Less than 9th grade	5	2%
Some high school	6	3%
High school graduate	53	24%
Some college (including jr. college)	34	15%
Bachelor's degree	56	25%
Graduate or professional training	67	30%
Total	*221*	
RELIGIOUS AFFILIATION		
Jewish	143	64%
Protestant	29	13%
Catholic	16	12%
Other	13	6%
None	12	5%
Total	*223*	
RACIAL/ETHNIC GROUP		
White/Caucasian	213	96%
Other	9	4%
Total	*222*	

SOCIAL DEMOGRAPHIC CHARACTERISTICS (Cont.)

CHILDREN		
Yes	187	85%
No	34	15%
Total	*221*	
BORN IN UNITED STATES		
Yes	180	81%
No	41	19%
Total	*221*	
(If foreign born) LENGTH OF TIME IN U.S.		
10 years or less	1	2%
More than 10 years	40	98%
Total	*41*	
CURRENTLY EMPLOYED		
Yes	17	8%
No	204	92%
Total	*221*	
TYPE OF HOUSING		
Single family	47	21%
Multiple family (2-3 family)	21	10%
Brookline Senior Public Housing	12	6%
Brookline Public Housing (not senior)	2	1%
Center Communities	58	26%
Other senior housing	5	2%
Apartment/condo (not senior housing)	76	34%
Total	*222*	

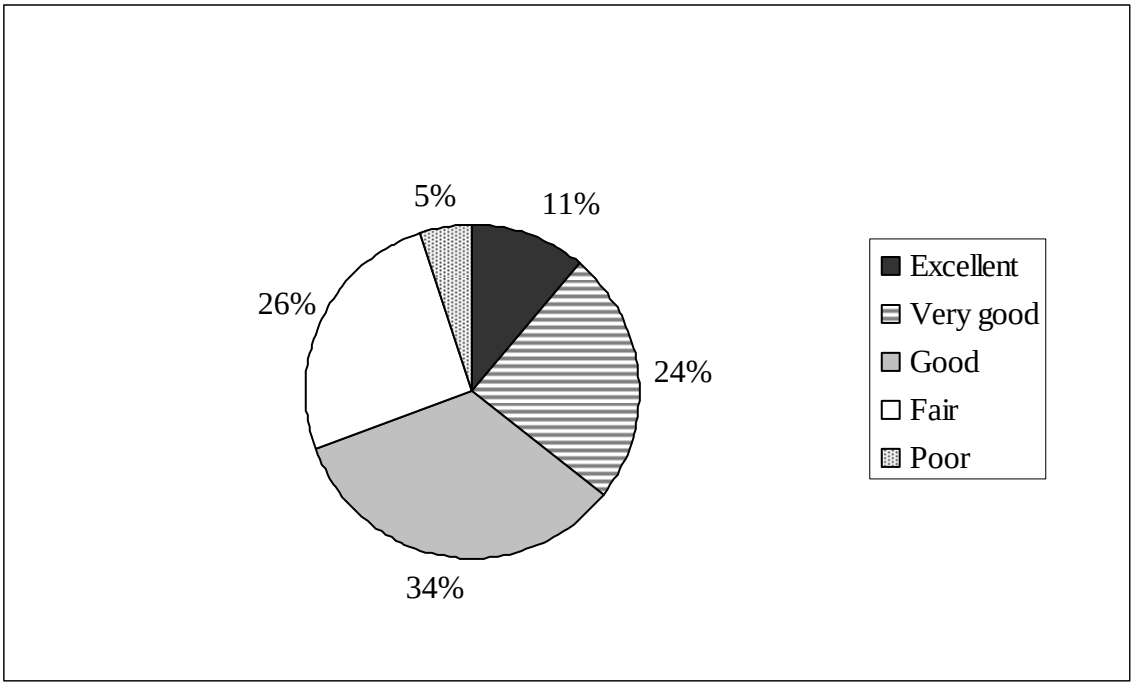
4.0 HEALTH

Since health is one of the major concerns affecting the quality of life for the elderly, this report begins by examining health issues. In later sections, health self-perceptions and disability status will be frequently-used lenses through which the areas of mental health, housing, transportation, social functioning, finances, and service needs will be viewed. This section also compares our survey data with other data where relevant comparisons exist.

4.1 Self- Reported Health Status

Respondents were asked to rate their health during the past month. Approximately one-third thought their health was either excellent (11%) or very good (24%); one-third thought it was good (34%); and one-third rated it as either fair (26%) or poor (6%). Self-perceptions of health were unrelated to age or sex.

Figure 4.1 Self-Reported Health Status during the Past Month



As Table 4.1 shows, there is a remarkable similarity in perceived health status between our survey data and data from other studies.

Table 4.1 Self-Reported Health Status - Comparative Data

	Good to Excellent	Fair or Poor
Aging at Home: A Survey of Brookline's 85 and Over Seniors (current report)	69%	31%
MassCHIP 2004-08, 85+ population[6]	70%	30%
Snapshot in the Lives of Community-Residing Elders 85 and Older (1997), Gerontology Institute, University of Massachusetts[7]	63%	37%
Older Americans 2008: Key Indicators of Wellbeing[8]	66%	34%

4.2 Health Problems That Interfered with Functioning

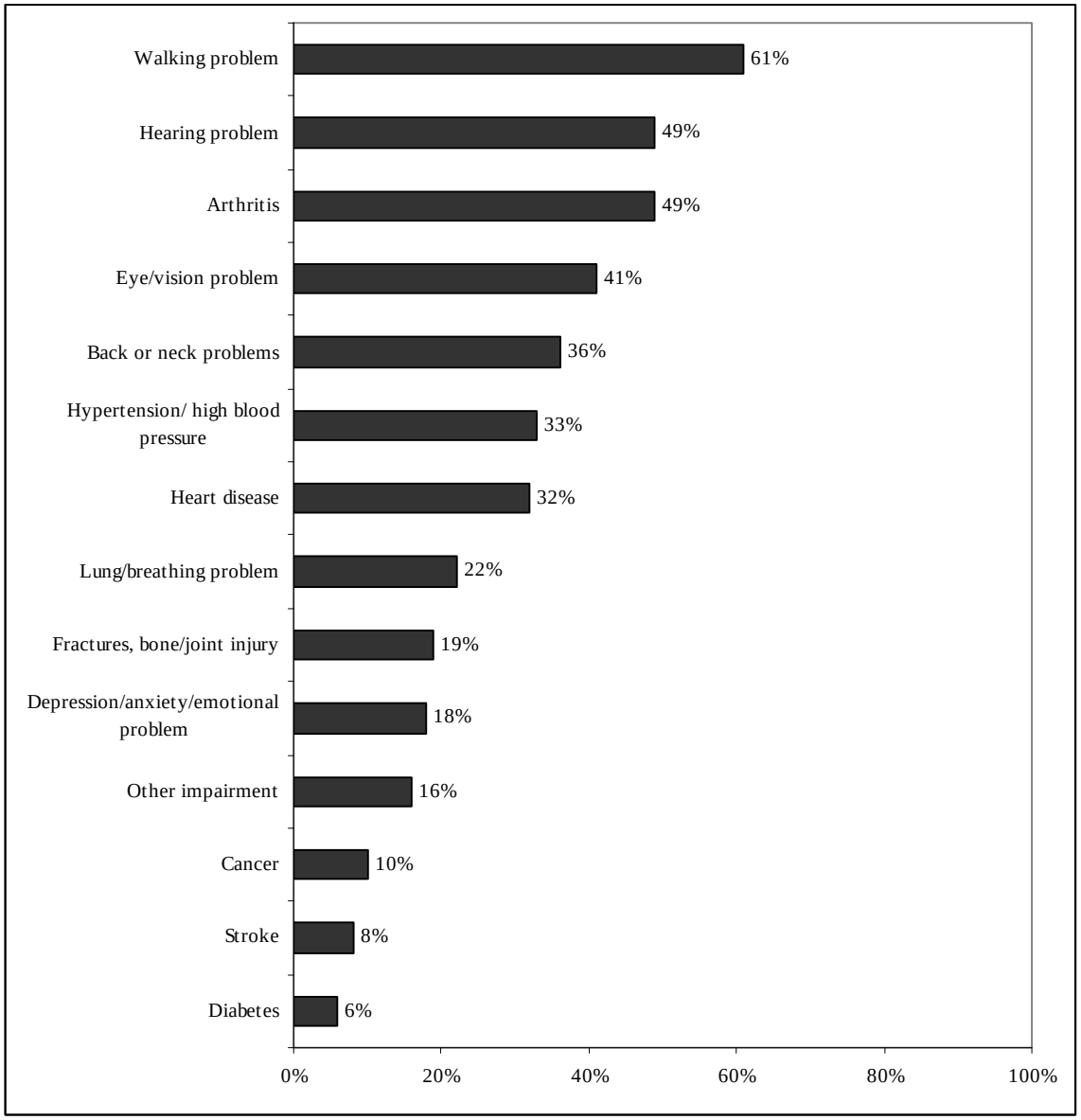
When asked whether they were *limited* in their activities, either inside or outside their home because of a physical condition or health problem, two-thirds indicated there were some limitations caused by health problems, and one third said there were no limitations. Among those with health problems that limited activities, 29 percent had one or two problems; 34 percent had three or four; and 37 percent named five or more health problems (mean = 4.0, S.D = 2.3). There were no differences by age or sex in regard number of health problems reported.

Our study data are somewhat comparable to other studies. *We the People: Aging in the United States*, a U.S. Census Bureau report based on the 2000 census indicates that 72 percent of people 85 and over reported some type of long-lasting condition or disability (p.11).[9] A 1997 study of an 85+ population conducted by the Gerontology Institute at University of Massachusetts reported that 60 percent of the respondents said physical impairments interfered with their activities during a pervious month (p.12). It should be noted that our study included physical and emotional problems as a health problem which could interfere with functioning, while the University of Massachusetts study reported on physical impairments.

[6] MassCHIP (Massachusetts Community Health Information Profile). 2004-2008 data for the 85+ population was aggregated by Maria McKenna, Epidemiologist, Health Survey Program, MA Department of Public Health (email communication, Dec. 1, 2009).
[7] Nina Silverstein and Bei Wu .*A Snapshot in the lives of Community-Residing Elders 85 and Older: Their Lifestyles, Contributions, and Concerns.* (Gerontology Institute and Center, University of Massachusets, Boston, 1997).
[8] *Older Americans 2008: Key Indicators of Wellbeing.* Retrieved 9/1/08. www.agingstats.gov.
[9] U.S. Census 2000, Special Reports. *We the People:Aging in the United States* (December 2004). Retrieved 8/17/10, <www.census.gov/prod/2004pubs/censr-19.pdf>.

The most frequently mentioned health problems were walking problems, hearing problems, and arthritis. The least frequently mentioned were cancer, stroke, and diabetes.

Figure 4.2
Major Health Problems That Limited Activities Inside or Outside the Home



4.3 Disability

There is no commonly accepted definition of disability and studies use different measures. However, research on the elderly often assesses disability in terms of health problems that cause limitations in daily activities and it distinguishes between Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). ADLs are the basic activities required for self-care, such as bathing, dressing, and toileting. IADLs are the more complex activities required for independent living, such as shopping, housework, and meal preparation. An inability to perform an ADL is believed to indicate

greater impairment. Our study asked people about 6 ADLs --- bathing or showering, dressing, toileting, getting in or out of a bed or a chair, eating, and walking across a room -- and 7 IADLs --- using the phone, doing housework, taking medications, preparing hot meals, shopping for groceries, managing money, and doing laundry. Fifty-two percent had no ADL or IADL problems and 48 percent had one or more ADL or IADL problems.

ADL and IADL problems were both related to age, although the patterns differed. In regard to ADLs, there were few differences between the 85-89 and 90-94 groups, while there was a sharp difference between these younger groups and the 95 and over group (chi-sq = 10.8, 2df, p<.01). In regard to IADLs, as people aged, there was an increase in IADL problems (chi-sq = 6.9, 2df, p<.05).

Figure 4.3
ADLs by Age

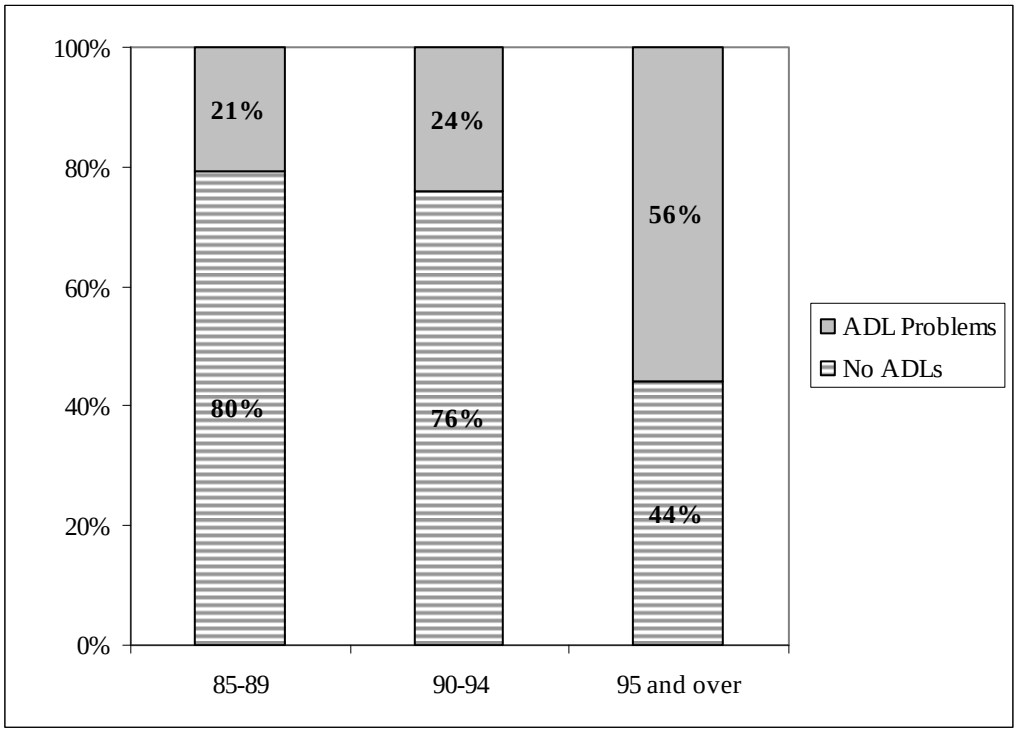
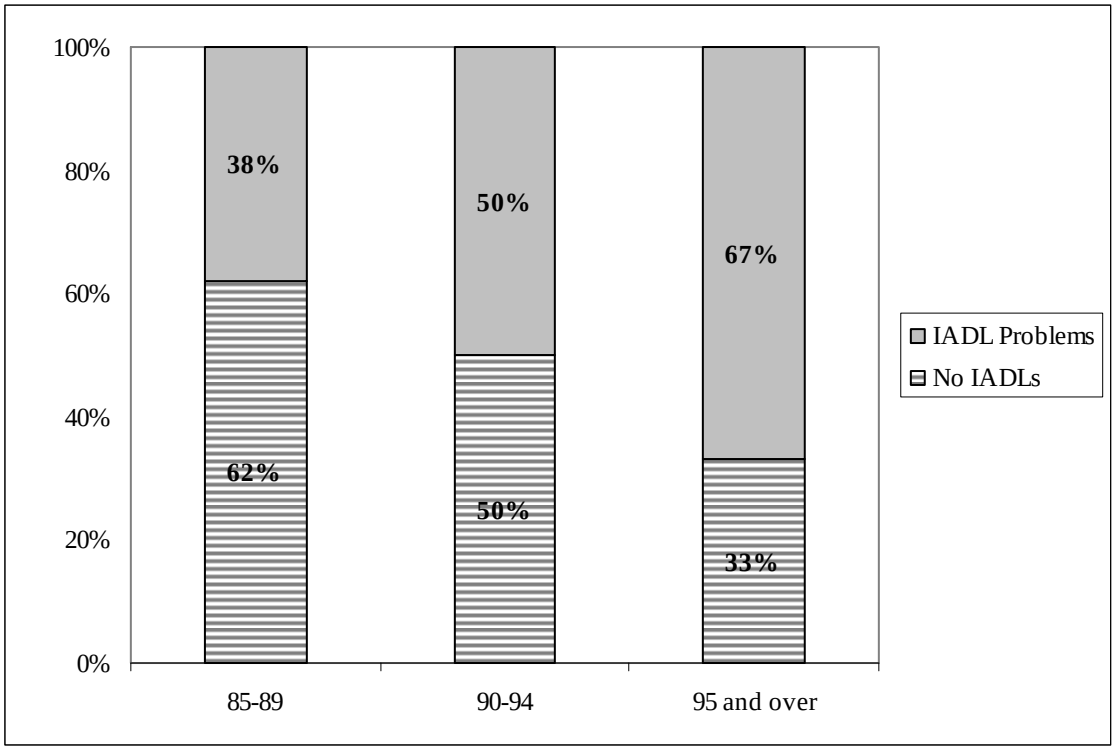


Figure 4.4
IADLs by Age



There were no differences between men and women in regard to ADL problems: 23 percent of the men and 25 percent of the women reported ADL problems. However, women were more likely to report IADL problems than men: 31 percent of the men and 48 percent of the women reported IADL problems (chi-sq = 5.6, 1df, p<.05). This pattern is may be due to gender role differences since women have traditionally carried out more of these responsibilities than men (e.g. shopping, housework, meal preparation, and laundry). This generation of men may never have had to assume responsibility for these functions and may still not perform many IADLs if they are currently married (55% of the men and 14% of the women in our study are married). If men do not need to perform these tasks because others perform them, they may not consider that they have difficulty with these activities.

In addition to analyzing ADLs and IADLs separately, this study used a combined measure of ADLs and IADLs called disability status. This measure was used by Richard W. Johnson and Joshua M. Winter in a 2006 Urban Institute report entitled *"A Profile of Frail Older Americans and their Caregivers:"*[10] those who had at least two ADLs or one or more IADLs were considered frail and those who had three or more ADLs were considered severely disabled.

[10] Richard W. Johnson and Joshua M. Wiener, *A Profile of Frail Older Americans and Their Caregivers*, (The Retirement Project, Urban Institute, Occasional Paper Number 8, February 2006). Retrieved 8/17/10, <www.urban.org/publications/311284.html>.

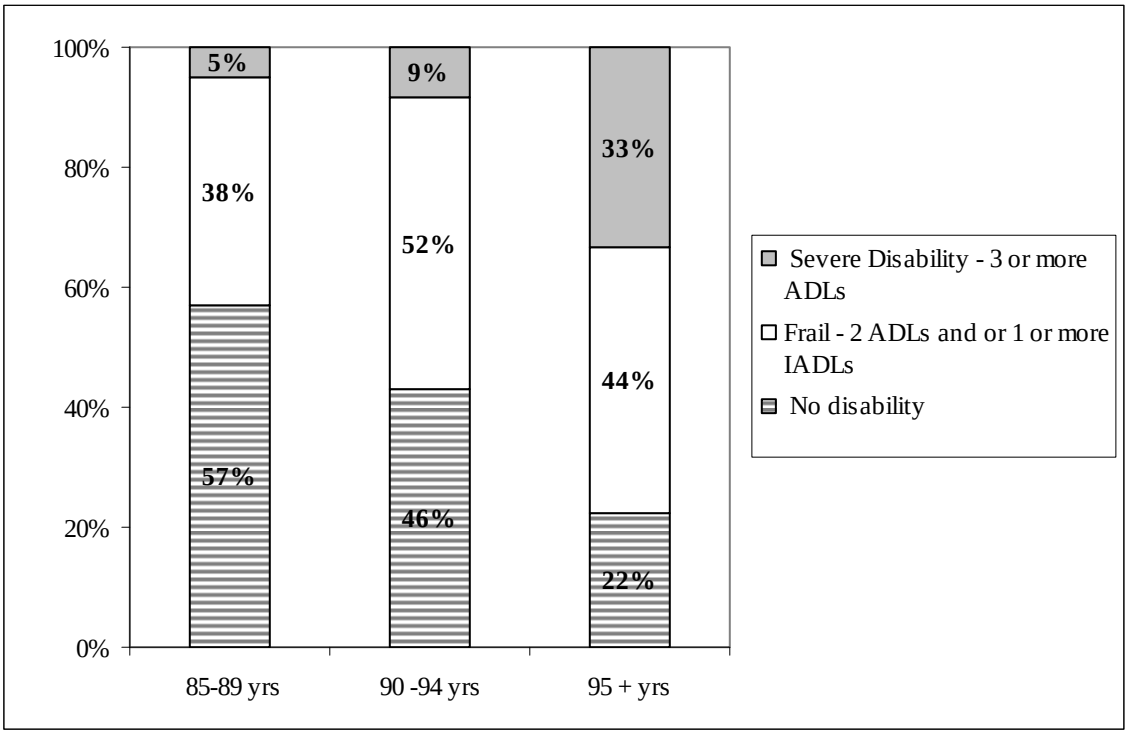
Using this categorization shows the following: over half (52%) had no disability and were able to manage the common activities of daily living on their own without difficulty; two-fifths (42%) were in the frail category, and 6 percent were in the severely disabled category.

Table 4.2 Disability Status (N=223)

No disability - No ADL or IADL Problems	52%	116
Frail - Problems with 1-2 ADLs or 1 or more IADLs	42%	93
Severe Disability - Problems with 3 or more ADLs	6%	14

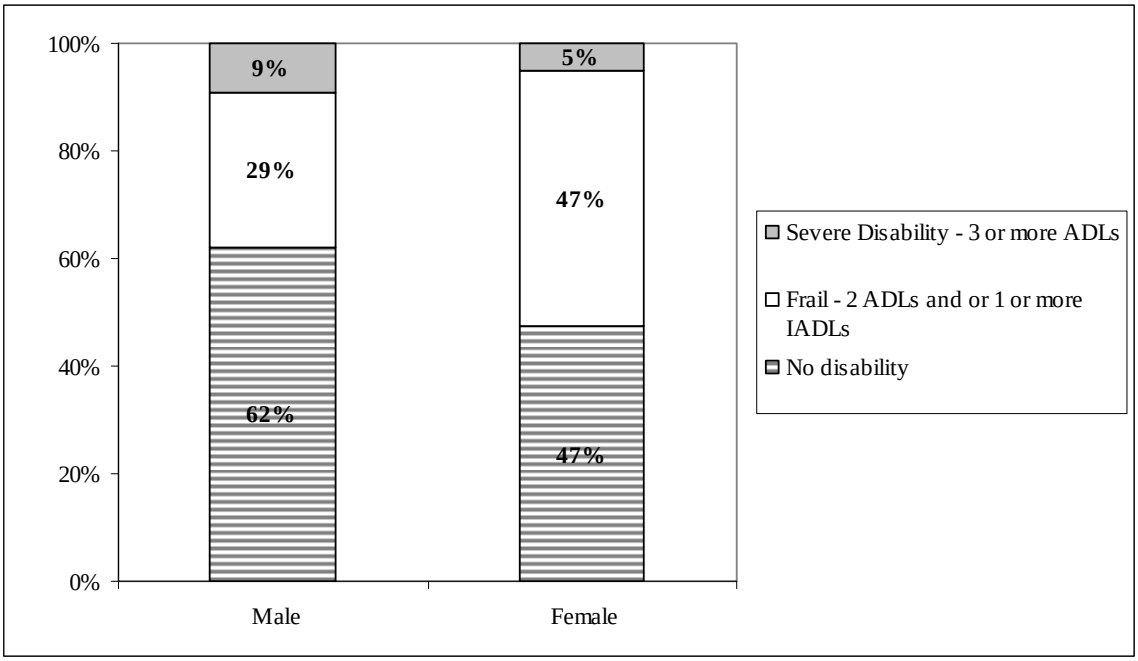
Not surprisingly, given the data presented earlier, there is a relationship between disability status and age (Fisher's Exact Test = 19.7, p<.001). Thirty-three percent of those in the 95 and older age group were severely disabled compared to 9 percent and 5 percent in the younger age groups (90-94 and 95 and over).

Figure 4.5
Disability Status by Age



There is also a relationship between disability status and sex (chi-sq = 6.7, 2df, p<.05). Although there are no differences between men and women in the severe disability category, there are differences between men and women in the no disability and frail categories: a higher percentage of men are in the no disability category while a higher percentage of women are in the frail category.

Figure 4.6
Disability Status by Sex



The study *"Older Americans 2008: Key Indicators of Wellbeing"* [11] reports that 38 percent of men compared to 56 percent of women in the 85 and older group have functional limitations. When we combine the severely disabled and the frail, this data is remarkably similar to our own.

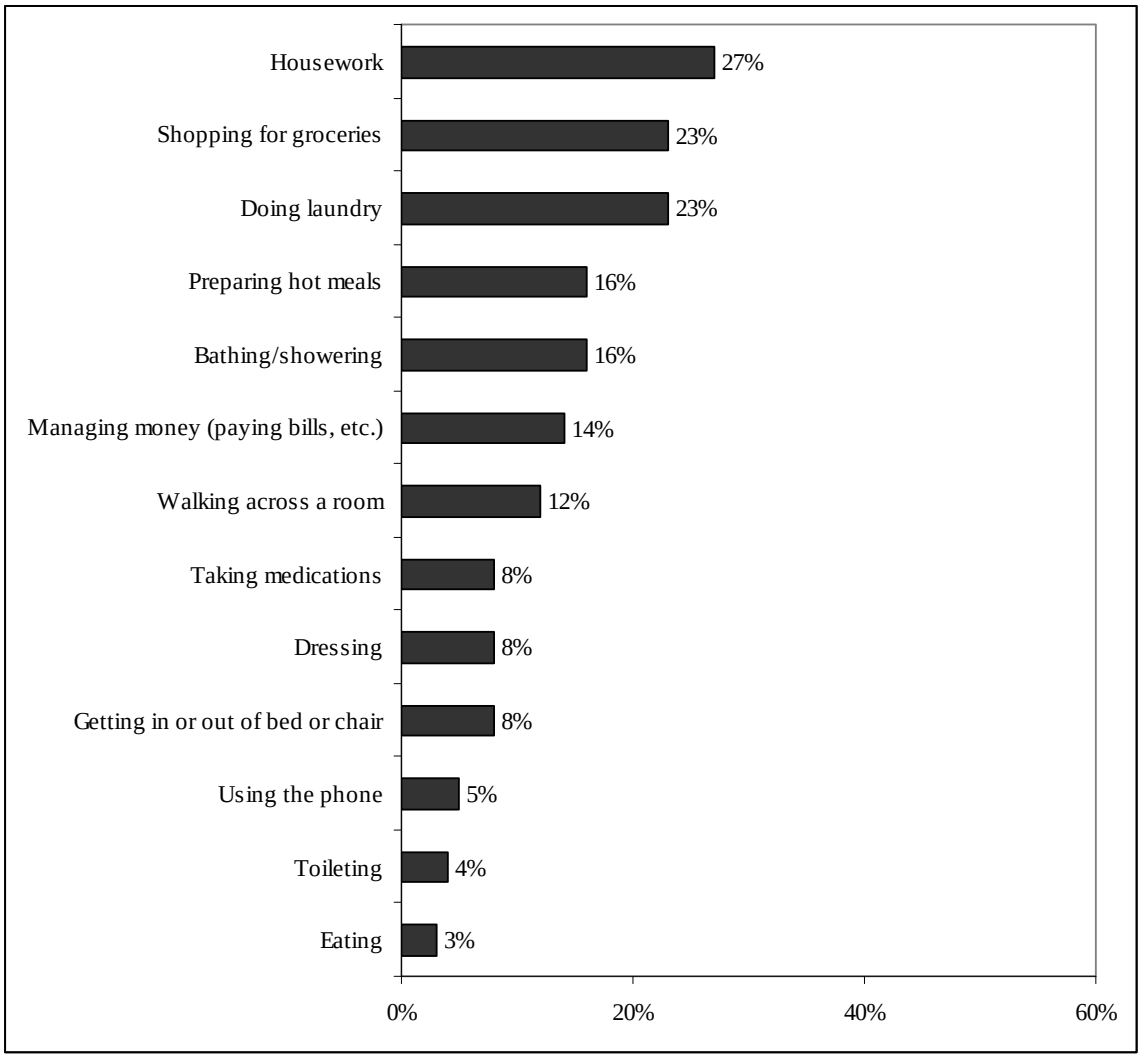
In addition, as would be expected, there is a relationship between disability status and self-perceived health rating: those who are severely disabled or frail are more likely than those with no disability to perceive their health status as fair or poor (Fisher's Exact Test = 27.8, $p<.001$).

4.4 Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL) that Present People with Problems

Looking now at individual ADLs and IADLs, respondents were asked whether they had difficulties doing common daily activities on their own without assistance during the past month. Figure 4.7 reports on the types of activities that caused difficulties. The three most frequently mentioned activities were: housework, shopping for groceries, and doing laundry, mentioned by approximately 23 to 27 percent. The three least frequently mentioned activities were: using the phone, toileting, and eating, mentioned by 5 percent or less.

[11] *Older Americans 2008: Key Indicators of Wellbeing, Table 20c* Retrieved 9/1/08. www.agingstats.gov.

Figure 4.7
Activities that People Find Difficult to do on Their Own



There are variations by sex. Women were more likely than men to have difficulties with shopping (27% vs.14%; chi-sq = 4.6, 1df, $p<.05$); housework (33% vs. 14%; chi-sq. = 8.4, 1df, $p<.01$); and laundry (27% vs. 14%; chi-sq = 4.6, 1df, $p<.05$). As discussed earlier, this is not surprising given that many men in our study are married and may not carry out these traditional female activities. A slightly higher percentage of the hearing impaired than the non-hearing impaired had difficulties with using the phone (11% vs. 3%, chi-sq = 4.7; Fisher's Exact Test, $p<.05$).

Age is significantly related to having difficulties with most activities of daily living. We expected to see a pattern of increasing difficulty with increasing age. However, that is not the case. There are minor differences between the 85-89 and 90-94 age groups, while the major difference is between these younger age groups and the 95 and over group.

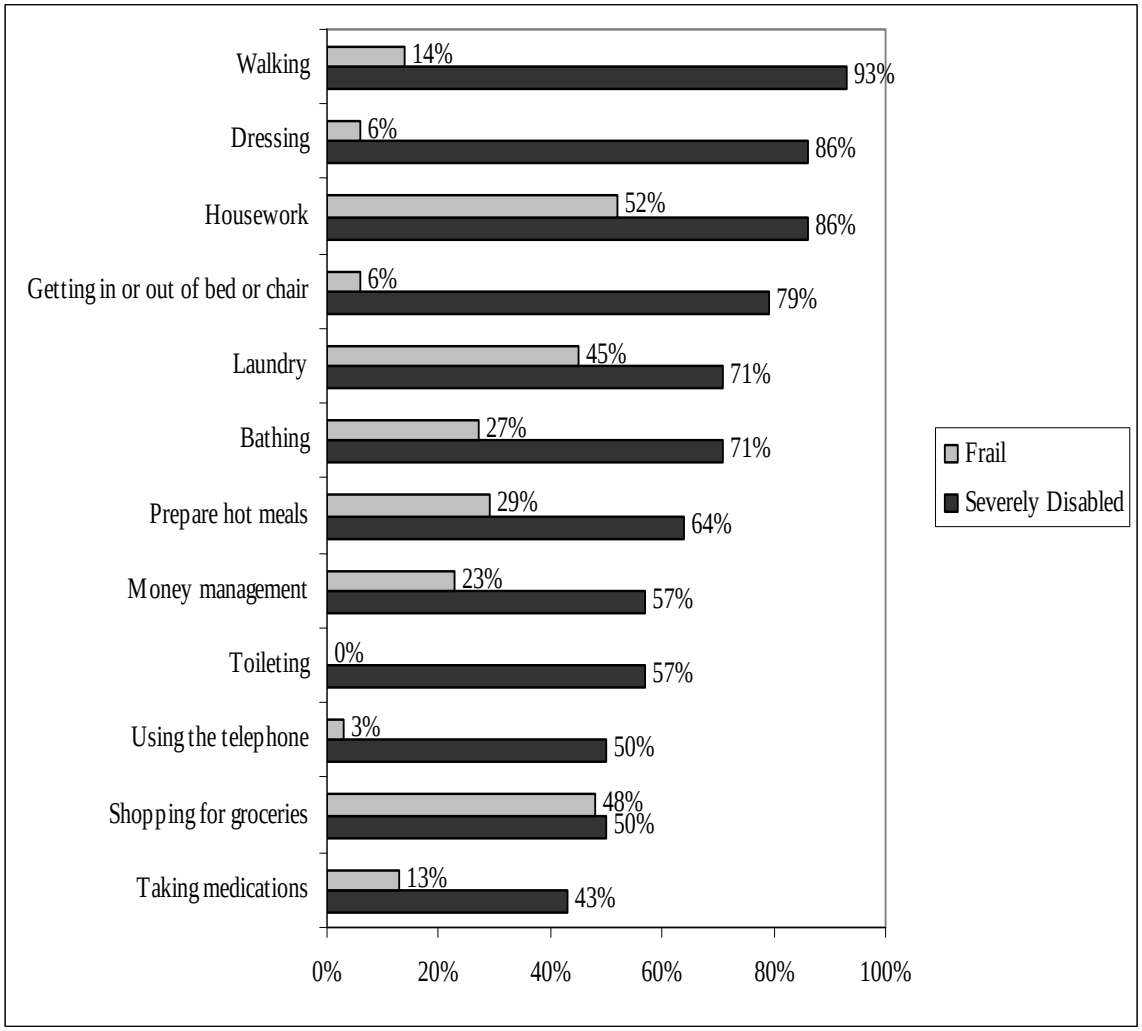
Table 4.3
Respondents Reporting Difficulty Managing Daily Activities by Age

	85-89 (N=151)	90-94 (N=54)	95+ (N=18)
Housework chi-sq = 7.9, 2df, p<.05	25%	26%	56%
Laundry chi-sq = 7.8, 2df, p<.05	21%	20%	50%
Walking across a room chi-sq = 22.3, 2df, p<.001	11%	4%	44%
Bathing chi-sq = 8.5, 2df, p<.05	13%	17%	39%
Preparing meals chi-sq = 7.8, 2df, p<.05	13%	17%	39%
Shopping for groceries n.s.	21%	26%	39%
Getting in or out of bed or chair Fisher's Exact Test = 12.8, p<.01	5%	7%	33%
Managing money (paying bills, etc.) chi-sq = 9.0, 2df, p<.05	14%	6%	33%
Dressing Fisher's Exact Test = 8.2, p<.05	7%	4%	28%
Using the phone Fisher's Exact Test = 9.4, p<.01	3%	4%	22%
Taking medications n.s., p<.10	7%	6%	22%
Toileting Fisher's Exact Test = 7.7, p<.05	3%	0%	17%
Eating Fisher's Exact Test = 8.8, p<.01	2%	0%	17%

It is striking to compare those who are frail with those who are severely disabled in regard to their ability to carry out ADL activities. Housework, shopping, and laundry were the activities that caused the most difficulties for the frail (48% to 52% had

difficulties with these activities). Fifty percent or more of the severely disabled had difficulties with all activities with the exception of taking medications where 43 percent had difficulties.

Figure 4.8
Difficulty Managing Daily Activities: Frail and Severely Disabled Compared



4.5 Assistance Received with Activities of Daily Living

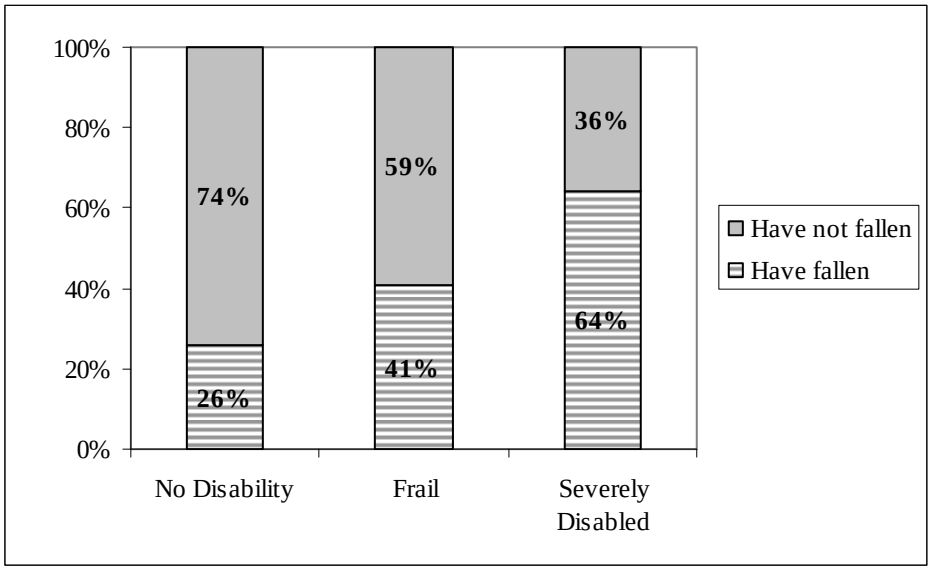
In the sample as a whole, 38 percent (85/223) were receiving help with ADLs or IADLs. Among those having difficulties with one or more ADL or IADL activities (107/223, the frail and the severely disabled), 79 percent were receiving assistance. Among this group, over half received help from relatives (53%) and nearly three-fifths (59%) received help from a home health aide, a homemaker, or a companion. Few people received help from friends/neighbors (5%) or volunteers (4%). An open-ended question asked whether others, in addition to those mentioned above, gave assistance. Eleven people mentioned paid household help.

Disability status was positively related to receipt of assistance. Almost all (93%) of the severely disabled and over three-quarters (77%) of the frail were receiving assistance while none of the non-disabled were receiving assistance (chi-sq = 147.6, 2df, p<.001). Age tended to be related to the receipt of assistance, although it did not quite approach statistical significance (chi-sq = 5.7, 2df, p<.10). Over three-fifths (61%) of those in the 95 plus group received assistance compared to 43 percent in the 90-94 group and 34 percent in the 85-89 group. There were no differences by sex. Men were as likely as women to receive assistance.

4.6 Falls

Falls are a big source of concern for the elderly since they can have a deleterious effect on health and often necessitate a change from independent living to nursing home or assisted living care. A little over one-third (35%) had fallen during the past year. Among this group, almost half (49%) fell inside their home; two-fifths (42%) fell outside; and 9 percent fell in both places. Over half (55%) of those who had fallen were injured as a result of their falls. Falls were not related to sex, but they were related to disability status: the higher the level of disability, the higher the percentage of people who had fallen (chi-sq = 10.7, 2df, 0<.01).

Figure 4.9
Falls by Disability Status



Location of falls showed a slight tendency to be related to age: the older the age, the more likely that falls occurred inside the home. Forty percent of those aged 85-89, 67 percent of those aged 90-94, and 86 percent of those aged 95 and over indicated their falls occurred inside their home. This pattern was not statistically significant, but it approached significance (p<.10).

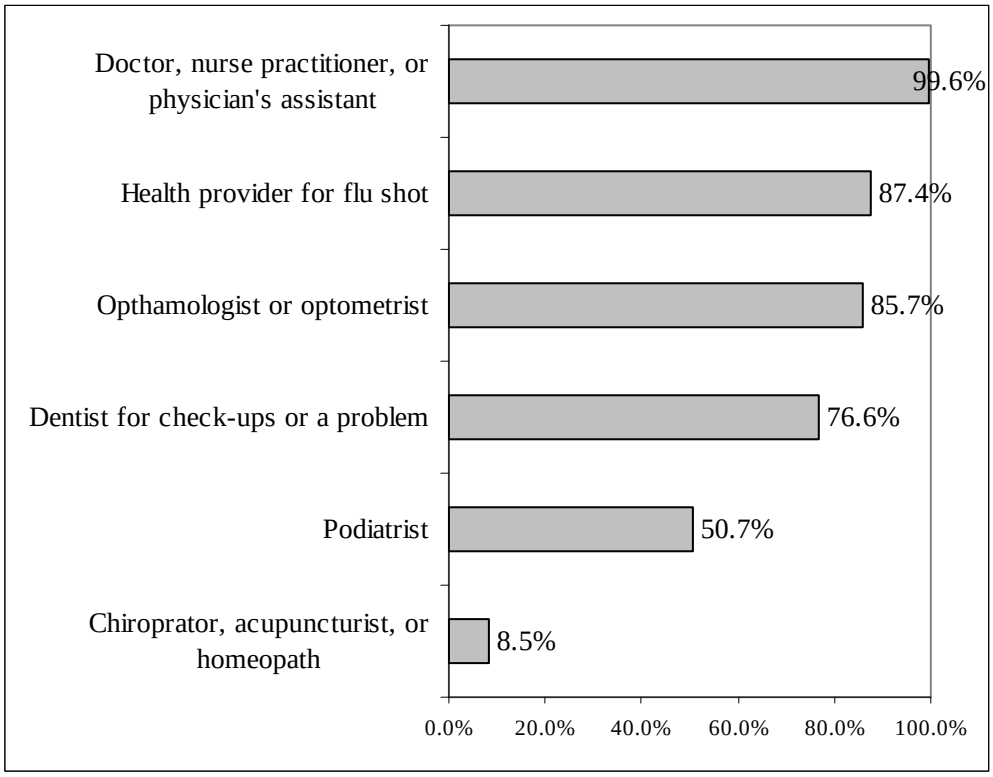
Fifty percent of the respondents used walking aids, (a cane, walker, wheelchair, or scooter). The use of walking aids was related to age: 45 percent of those aged 85-89, 52 percent of those aged 80-94, and 83 percent aged 95 and over used walking aids (chi-sq = 9.6, 2df, p<.01). People who had fallen were more likely to use walking aids than those who had not fallen: 66 percent of those who had fallen and 41 percent of those who had

not fallen used walking aids (chi-sq = 13.1, 1df, p<.001). Although two-thirds of those who had fallen did use walking aids, 34 percent did not use them. We do not know whether walking aids were used at the time of the fall or whether people started using them after the fall.

4.7 Health Professionals Seen During the Past Year

During the past year, almost all had seen a doctor, a nurse practitioner, or a physician's assistant for a check-up or because they were ill. Over four-fifths had seen a health provider for a flu shot; over four-fifths had seen an ophthalmologist or optometrist; more than three-quarters had seen a dentist for check-ups or for a problem; and half had seen a podiatrist. Few respondents (9%) saw alternative medical professionals (acupuncturists or homeopaths) during the past year. There were no variations by age. However, women were more likely to see podiatrists than men (57% vs. 34%, chi-sq = 8.6, 1df, p<.01); the severely disabled and those with financial problems were less likely to have seen a dentist during the past year (90% and 66%, chi-sq = 26.0, 2df, p<.001); and those with financial problems were somewhat less likely to have seen a dentist (62% vs. 78%, chi-sq = <.10).

Figure 4.10
Types of Health Professionals Seen During Past Year



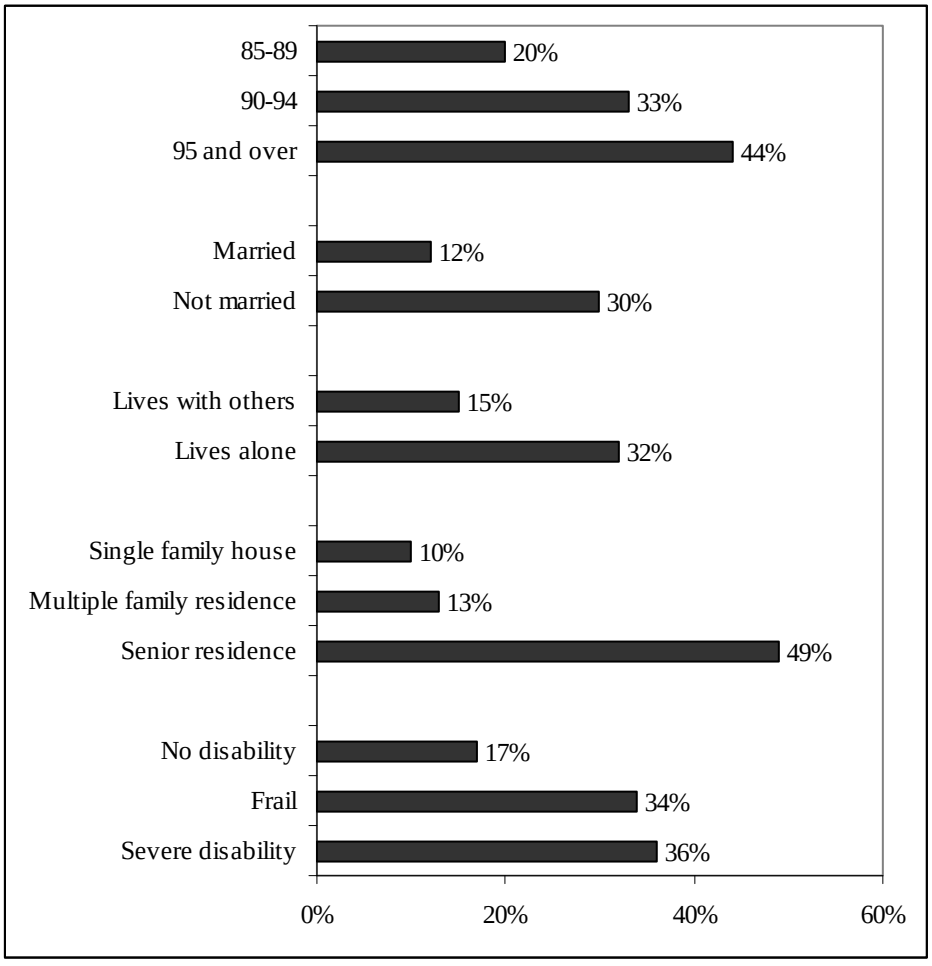
MassCHIP data from 2004-2008 for residents 85 and older indicate that 91 percent had a check-up within the past year and 78 percent had a flu shot. Our survey data show slightly higher percentages for both health-related actions. The Brookline community is easily- accessible to medical care which may account for the higher percentages. It is also possible that the people who agreed to participate in our survey were more health-conscious.

4.8 Meal Preparation and Nutritional Concerns

Seventeen percent regularly have lunch or dinner in a group setting, such as a senior housing residence or the Brookline Senior Center (lunch only), and 9 percent receive Meals on Wheels. Age is related to eating meals in a group setting. Thirteen percent of those 85-89, 24 percent of those 90-94, and 33 percent of those 95 and over have meals in a group setting (chi-sq = 7.4, 2df, $p<.05$). Receiving Meals on Wheels is related to disability status. Fourteen percent of the severely disabled, 15 percent of the frail and 4 percent of those with no disabilities receive Meals on Wheels (chi-sq = 7.2, 2df, $p<.05$).

In all, 25 percent (56 people) have one or more meals prepared by an outside source (Meals on Wheels, senior residence, Brookline Senior Center). Having meals prepared by an outside source is related to age (chi-sq = 7.3, 2df, $p<.05$), marital status (chi-sq = 7.1, 1df, $p<.01$), living arrangement (chi-sq = 8.1, 1df, $p<.01$), type of residence (chi-sq = 35.2, 2df, $p<.001$), and disability status (chi-sq = 9.3, 2df, $p<.05$)

Figure 4.11
Percent Having One or More Meals Prepared by Outside Source(s)

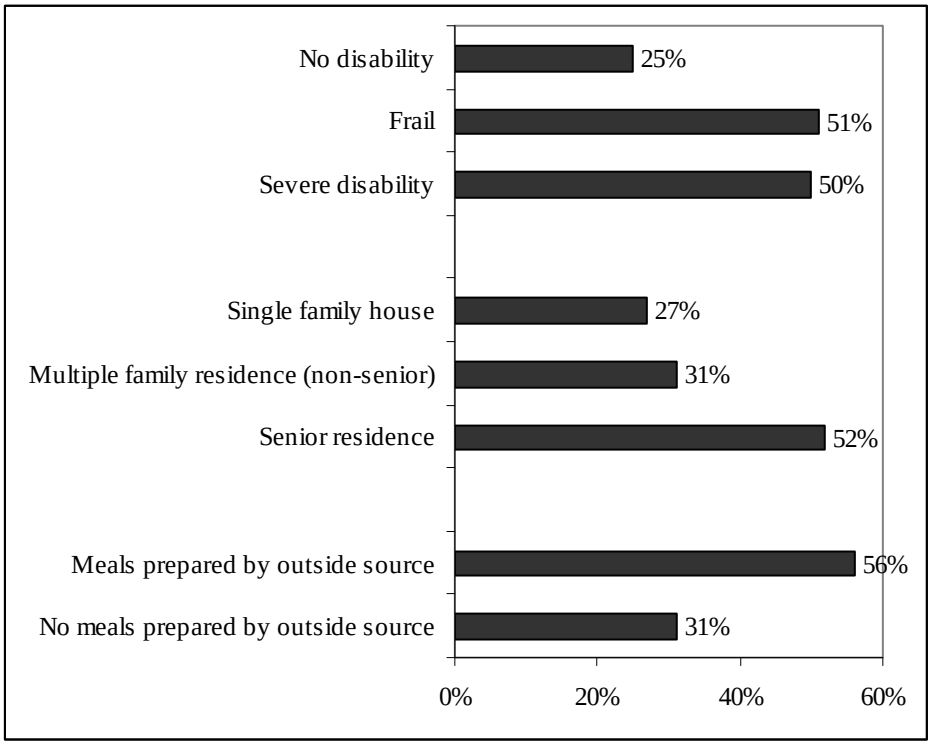


Respondents were asked about nutrition concerns. The questionnaire contained 5 items. Thirty-seven percent mentioned one or more concerns. “Losing weight without trying”

was the most frequently-mentioned concern, mentioned by 19 percent. Twelve percent were concerned about "gaining weight;" 9 percent indicated they were "eating poorly because of a decreased appetite;" 5 percent said "tooth and mouth problems that make it hard to eat;" less than 1 percent said they were "eating fewer than two meals a day;" and 8 percent mentioned "other" nutrition problems.

Having nutrition concerns was related to disability status (chi-sq = 16.2, 2df, p<.001), type of residence (chi-sq = 10.5, 2df, p<.01), and having one or more meals prepared by an outside source (chi-sq = 10.4, 2df, p<.01). Twenty-five percent of those with no disability, 51 percent of the frail, and 50 percent of the severely disabled mentioned nutrition concerns Twenty-seven percent of those who lived in single family housing, 31 percent of those who lived in multi-unit, non-senior housing, and 52 percent who lived in senior housing had nutrition concerns. Fifty-six percent of those who had one or both meals prepared by an outside source compared to 31 percent whose meals were prepared in-house had nutrition concerns.

Figure 4.12
Percent Having Nutrition Concerns



The "other" concerns mentioned included:

Dietary constraints:

"*Very limited diet.*"

"*As a diabetic, I try to be sugar free.*"

"*Must eat slowly and not too heavy.*"

"*Would like to eat more veggies and not clear why I can't.*"

Health concerns:

"*Afraid of choking.*"

"*Problems with bowels results in poor appetite.*"

"*Constipation is a constant problem.*"

"*Some medications make me sick to my stomach.*"

Food is unappealing:

"*I find the foods served to be unappetizing.*"

"*Would like food to be better prepared.*"

Financial constraints:

"*I wish I could buy more food*"

4.9 Medications

Almost all (96%) reported that they were taking medications on a regular basis. Eight were not taking any medications. Among those taking medications, 29 percent had concerns about medications. Having concerns was related to level of education: 23 percent of those with less than high school education, 20 percent of those who were college graduates or had some college education, and 47 percent of those with advanced educational degrees had medication concerns (chi-sq = 15.1, 2df, $p<.001$). Twenty-two percent had one concern, and 7 percent had two or three concerns. Fifteen percent mentioned "sometimes forgetting to take medications;" 11 percent were concerned "about side effects or drug interactions;" 7 percent wondered "whether they were taking medications correctly;" and 3 percent mentioned "other" concerns, including:

Problems taking medications:

"*I have difficulty swallowing pills*"

"*I sometimes get my medications mixed up.*"

Information needed about medication:

"*Concerned about taking prednisone*"

"*I wonder if two of them are needed*"

"I need to check with my MD."

"My current inhaler is no good."

"Will speak to doctor. Would like to get off some meds."

Concerns about the expense:

"Too expensive" (2)

4.10 Physical Activity

Respondents were asked whether they currently engaged in a physical activity, such as walking, dancing, yoga, or gardening for at least half an hour three or more times a week. Nearly three-fifths of the respondents (58%) said "yes." In the MassCHIP data set (2004-2008), only 10 percent of those aged 85 and older said they engaged in regular leisure-time physical activity, and, thus, our data seem unusually high. Even if we assume that people who agreed to participate in our study might tend to be more health-conscious, this figure is still quite high.[12]

Physical activity was not related to age or sex, but it was related to disability status: 72 percent of those with no disability, 44 percent of the frail, and 36 percent of the severely disabled engaged in physical activity three or more times a week (chi-sq = 2df, $p<.001$). As can be seen, the biggest difference is between those with no disability and those with a disability (whether frail or severely disabled). Physical activity was also related to falls. People who engaged in physical activity for at least half an hour three or more times a week were less likely to have fallen during the past year compared those who had not engaged in this type of physical activity (27% compared to 45%; chi-sq =7.8, 1df, $p<.01$).

[12] The difference may be due to the wording of the questions.

4.11 ADL or IADL Needs and Pressing Concerns

Respondents were asked if they needed assistance with activities of daily living. Eight percent or 17 respondents had needs for ADL or IADL assistance.

Table 4.13 ADL or IADL Needs (N=223)

	N	%
Help with housework or laundry	11	4%
Help with shopping for groceries	6	3%
Help with bathing or dressing	2	<1%
Help with meal preparation	2	<1%
Information about Meals on Wheels	0	0
Total number of respondents with ADL/IADL needs	**17**	**8%**

Needing assistance with ADLs/IADs was related to depression (Fisher's Exact Test = 8.7, $p<.05$) and disability status (chi-sq = 2df, $p<.01$). Those who were depressed had more ADL or IADL needs. People who were frail had more ADL or IADL needs than the severely disabled, possibly because the severely disabled were already receiving assistance.

Although only 8 percent said they needed ADL or IADL assistance, when asked about their most pressing concerns, people who had not indicated a need for assistance mentioned concerns about their ability to carry out their household tasks and/or their problems finding people to help them with their housekeeping activities. They made comments such as:

> *"While I'm able to do housework, I'm finding it increasingly difficult. Could use some help."*
>
> *"I need a little help to remain in my house."*
>
> *"A local agency provides help, but they have cut down their hours. Homemaker isn't coming as much as she used to."*
>
> *"Although I have help, I'm not getting as much help as I need and what I'm getting isn't satisfactory."*
>
> *"I'm not so satisfied with my home health aides – the quality of their work-- but I'm afraid to complain."*

4.12 Health Needs and Pressing Concerns

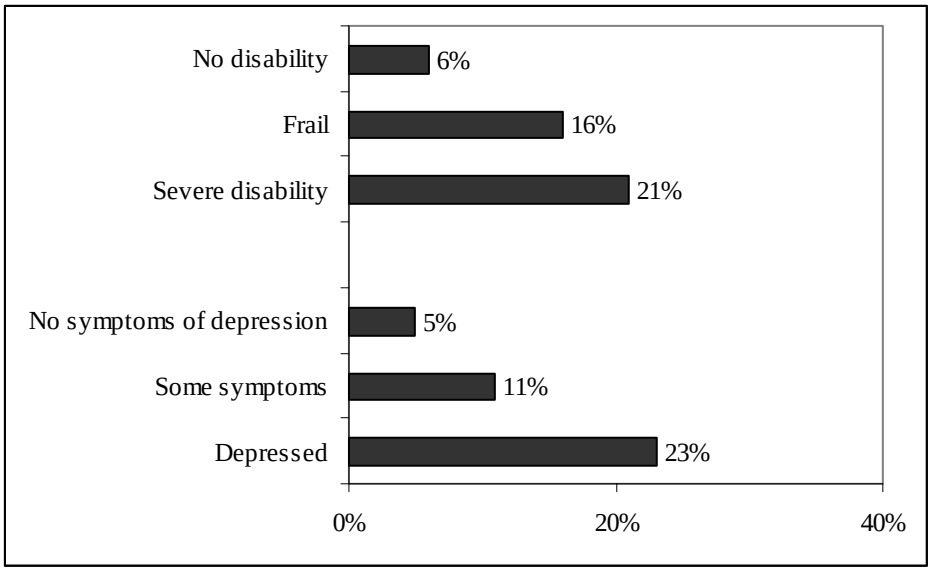
Respondents were asked if they needed any information or any services because of health.concerns. Eleven percent or 25 respondents said "yes.".

Table 4.14 Health Needs (N=223)

	N	%
Health plan coverage	8	4%
Cost of health plan	9	4%
Help understanding insurance coverage for medications	8	4%
Speak to someone about memory concerns	8	4%
Cost of medications	7	3%
Speak to someone about feeling sad or lonely	6	3%
Information about diet and eating habits	4	2%
Other health concerns	3	1%
Assistance with medications or reminders	3	1%
Medication concerns	1	<1%
Total number of people with health needs	**25**	**11%**

Health needs were related to disability status (chi-sq = 6.6, 2df, p<.05) and depression (chi-sq = 6.7, 2df, p<.05). The severely disabled and those who were depressed were more likely to have needs for health-related information or services.

Figure 4.15
Percent with Health Needs by Selected Characteristics



When asked about their most pressing concerns, fifty-three respondents (23%) mentioned health (specific health concerns, general health concerns, concerns about becoming a burden on others, and concerns about what lies ahead). The following are examples of some of the concerns mentioned:

Specific health concerns:

"I have back problems that limit my ability to walk distances."

"My arthritis. I worry about what I'll do if I do become incapacitated."

"Fear of falling or having a stroke."

"My health is not so good. I have kidney failure and can't get around very well."

"Being able to function and taking care not to fall."

"Getting help in case of emergency. I'm looking into getting an emergency call system I can wear."

"I experience angina when I wake up."

"I get dizzy spells and they upset me. I'm afraid of Alzheimer's Disease, and I have trouble remembering things."

"I need a hip operation, I'm afraid to have it and won't. Can't walk without the operation."

"I don't want to fall".

"My eyesight is going. I am almost blind. I'm not sure what will happen when I can't see at all."

"I have physical limitations, pain, and atrial fibrillation."

"My health. I had cancer and have heart problems."

"Getting around. I have a use a walker to get around. It's not enjoyable to use a walker."

General health concerns:

"Physical limitations"

"I'm on a precarious plateau and fear falling off the plateau."

"Want to continue to be well enough to take care of myself without help."

"Want to continue to be physically fit".

"That my health continues without a lot of pain."

"Fear of decline."

"Health and aging."

"To stay healthy." (12)

"I'm fearful of accidents and ill health."

"I'm concerned about my health."

Becoming a burden on others:

"Becoming a burden on wife."

"Not to be a burden on children." (2)

"Staying healthy, doesn't want to be a burden."

"I do not want to be a burden on my family, so I hope I don't lose my mind."

Unpredictable future:

"End of life care. I'd like to speak to someone about that."

"Future care for myself"

"Concerned about future"

"The future – where will we end up?"

"The unknown"

"The future – How am I going to manage? I'm not as strong as I was. How long will I be able to keep the house?"

"I'm concerned that future health issues may change my lifestyle."

"I'm a worrier" I'm getting a listing of furniture, etc. to make it easier for survivors."

"My health is good but at 92 I worry about continuing to do well."

"Future health concerns."

“I'm afraid my health may fail in the future and cause me to have to go to a nursing home.”

“After 85, I began to wonder/worry about the future. I try not to project into the future, but it’s inevitable. I fear the unknown.”

“What are my choices if I become unable to care for myself? Losing my independence.”

“I think about the time I will die.”

“I'm concerned that future health issues may change my lifestyle.”

“I'm afraid my health may fail in the future and cause me to have to go to a nursing home. I love my present housing arrangement and neighbors.”

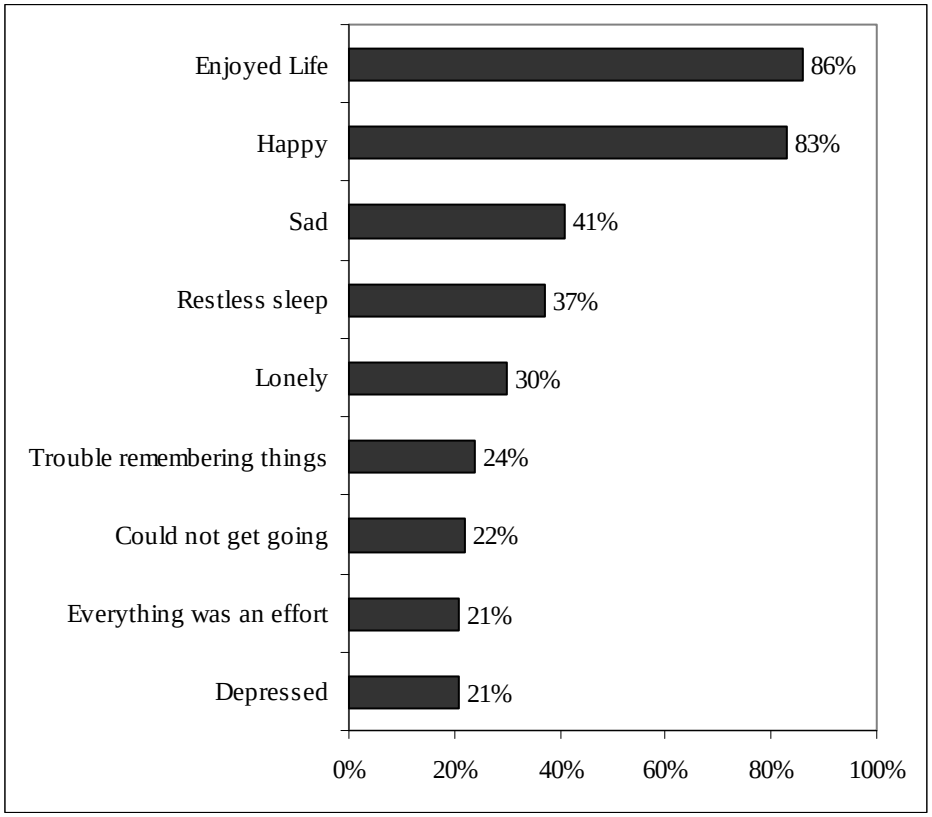
“I wonder what will happen if I get sick. Since my daughter and family live so close by, I'm confident they will make the right decisions.”

5.0 MENTAL HEALTH

5.1 Mood: Feelings Experienced "Often" During the Past Month

To get a sense of how people felt about their lives, the survey examined mood during the past month, adopting a set of 9 items used in two well-known national health studies, the Health and Retirement Study (HRS) and the Asset and Health Dynamics Among the Oldest Old Study (AHEAD). HRS is a national study of people 50 years and older and AHEAD is a national study of people 70 years and older. Interviewers asked respondents, "Were there times during the past month when you 'often' experienced any of the following feelings?" The list included the following items: "Felt depressed," "Felt everything you did was an effort," "Felt your sleep was restless," "Felt happy," "Felt lonely," "Enjoyed life," "Felt sad," "Felt you could not get going," and "Had a lot of trouble remembering things." As Figure 5.1 shows, over 80 percent said they "Enjoyed life" and were "Happy." These positive responses, however, did not preclude people from also saying they "often" had some negative feelings. Between 20 and 40 percent mentioned negative feelings. Twenty-four percent said they "Had a lot of trouble remembering things."[13]

Figure 5.1
Feelings Experienced "Often" During Past Month



[13] Data from the Health and Retirement Study published in Older Americans 2008: Key Indicators of Wellbeing, www.AgingStats.gov, indicate that 32 percent of people 85 and over had moderate or severe memory impairment (see Table 17). In our study 24 percent said they "often" had trouble remembering things. Note that the Health and Retirement Study had a strict definition of moderate or severe memory impairment, while our study simply asked people if they "often" had trouble remembering things.

5.2 Depression

The HRS/AHEAD studies developed a scale to measure depression using 8 of the 9 items seen in Figure 1 (trouble remembering things was excluded). Since depression is the most common psychiatric ailment in the elderly population, depression was measured using this scale.[14] The HRS/AHEAD studies use a dichotomous "yes" or "no" scale format and ask respondents whether they experienced certain feelings *"much of the time"* during the *past week*. The present study adapted this format by asking if they experienced these feelings "*often*" during the *past month*. The Depression scale was created by reversing the coding of the two positive items, "Enjoyed life" and "Felt happy" and summing the eight items (excluding the item about memory problems). Table 4.1 shows that 30 percent of the respondents answered "no" to all eight items, while the remaining 70 percent answered "yes" to one or more items.

Table 5.1 Depression Scale: with 2 items reversed (N=208)

Number of Items	N	%
0	63	30
1	45	22
2	33	16
3	19	9
4	17	8
5	12	6
6	12	6
7	5	2
8	2	1

The Depression Scale was divided into 3 groups to separate those who are depressed from those who have some symptoms or no symptoms at all. The literature suggests two ways of categorizing depression using this 8 item scale. The Health and Retirement Study (HRS) considers 4 or more symptoms to be indicative of depression (Table 19b, from Older Americans 2008: Key Indicators of Wellbeing, www.AgingStats.gov). The Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R, 3rd edition) considers that 5 or more symptoms indicate the presence of major depression (HRS/AHEAD Documentation Report, p. 8). This study uses 5 or more symptoms as the cut-off since it is a more stringent measure of depression. Thus, the Depression Scale was divided into the following groups: Group 1 – no depressive symptoms; Group 2 – 1-4 depressive symptoms; and Group 3 – 5-8 depressive symptoms. As Table 4.2 shows, 15 percent (31) of the respondents can be classified as depressed.

[14] These studies use eight items from the twenty item Center for Epidemiological Studies Depression Scale (CES-D) to measure depression. Documentation for the eight item scale indicates that it is easily administered either in person or over the telephone by people without professional training in psychiatry or psychology. Thus, it was a good measure for our study.

Table 5.2 Depression Scale - 3 Categories (N=208)

	N	%
No depressive symptoms- no items	63	30
Some symptoms, 1-4 items	114	55
Depressive symptoms- 5-8 items	31	15

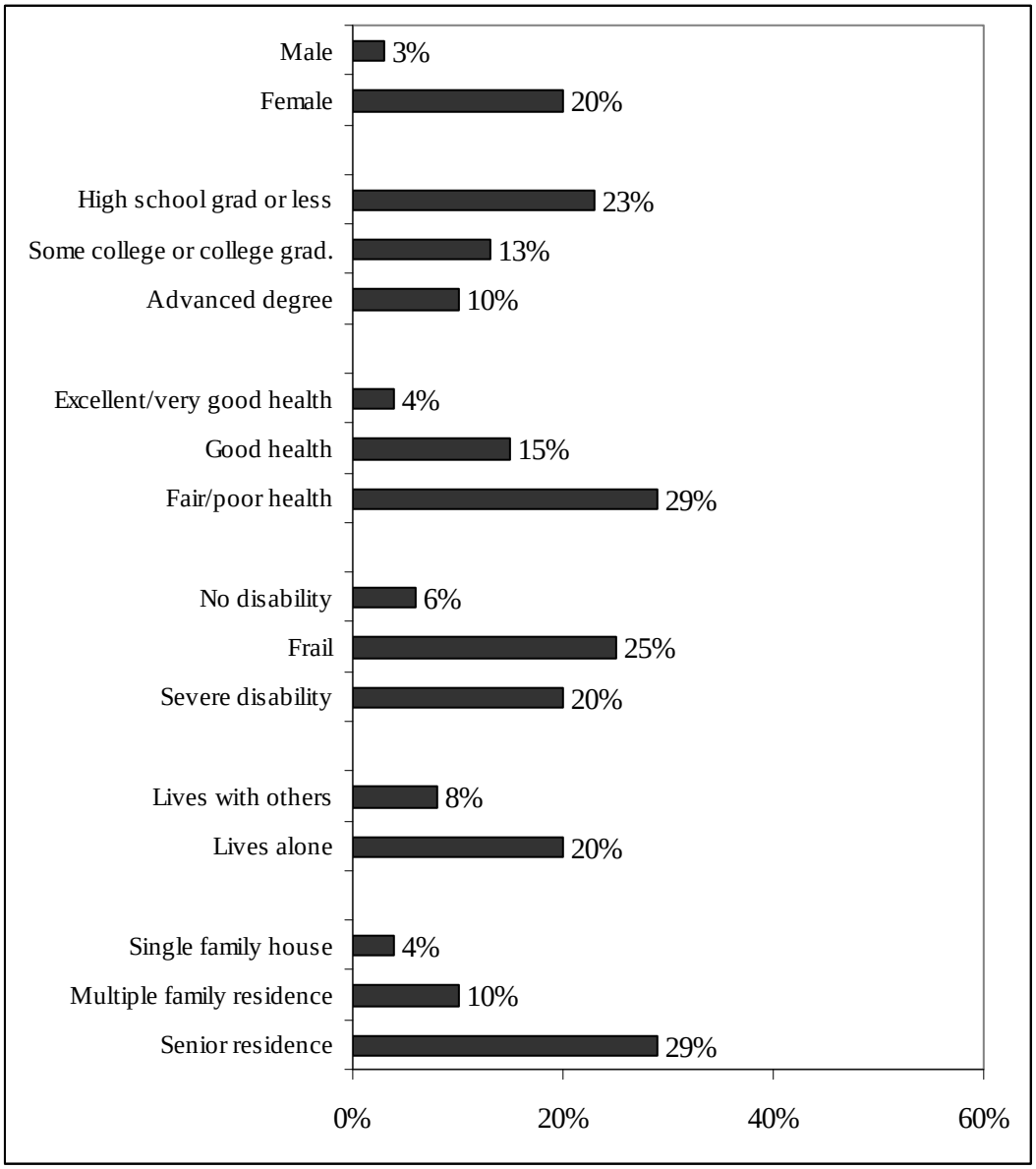
5.3 Comparative Data

The Health and Retirement study (which uses 4 symptoms as the cut-off) indicates that 19 percent of respondents 85 and older have clinically relevant depressive symptoms (Table 19b, *Older Americans 2008: Key Indicators of Wellbeing*, www.AgingStats.gov). If the present study used 4 symptoms as the cut-off, 23 percent of the respondents would be classified as depressed. In either case, our data are somewhat similar to the national data.

5.4 Characteristics of People Who Were Depressed

Women tended to have more depressive symptoms than men. Using 5 or more symptoms as the cut-off, 20 percent of the women compared to 3 percent of the men were depressed (chi-sq = 11.1. 2df, $p<.01$). Other factors related to depression were: self-reported health status (chi-sq = 20.1, 4df, $p<.001$), disability status (Fisher's Exact Test= 26.7, $p<.001$), living alone (chi-sq = 8.5, 2df, $p<.05$), and residence type (chi-sq = 17.3, 4df, $p<.01$). People who considered their health was "fair" or "poor," who were frail or severely disabled, who lived alone, or who lived in a senior residence were more likely to be depressed than others. There was a slight tendency for those with less education (high school graduate or less) to have more depressive symptoms than those with more education (some college, college graduate, or advanced degree). This pattern approached statistical significance (chi-sq = 9.3, 4df, $p<.10$).

Figure 5.2
Percent Who Were Depressed (5 or more symptoms)
by Selected Characteristics



5.5 Common Activities of Daily Living and Depression

We examined whether there was a relationship between having difficulties with the common activities of daily living (the ADLs and the IADLs) and depression. There were relationships between depression and having difficulties with housework responsibilities and shopping. Twenty-six percent of those who had difficulty with housework were depressed compared with 11 percent of those who did not have difficulty (chi-sq = 12.0, 2df, $p<.01$). Twenty-six percent of those who had difficulty shopping were depressed compared with 12 percent of those who did not have difficulties (chi-sq = 7.2, 2df, $p<.05$). As reported earlier, women tend to exhibit more depressive symptoms than men. Since housework and shopping are two of the primary responsibilities that women carry

out for most of their lives, perhaps the inability to carry out these activities contributes to their depression.

5.6 Use of Resources for Emotional Problems

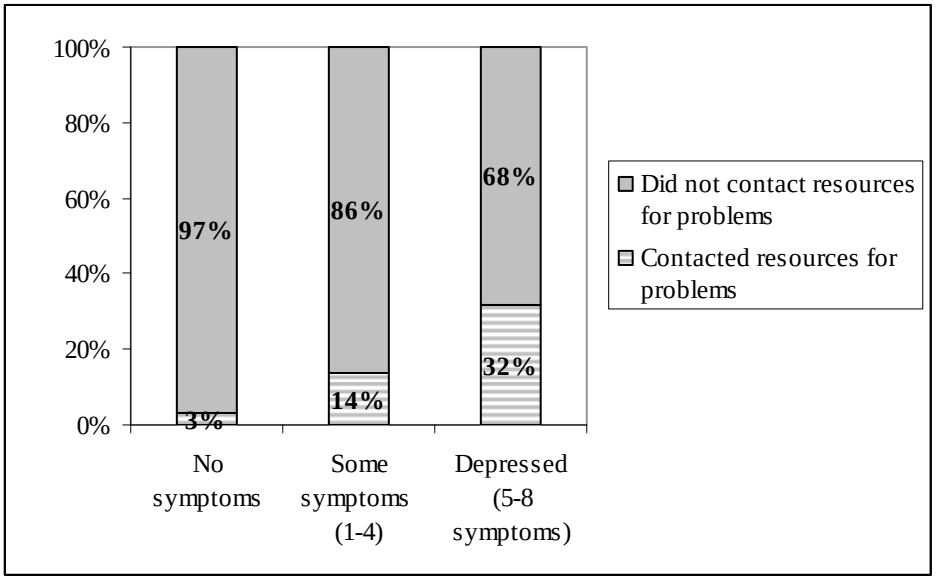
Respondents were asked whether they sought help for emotional problems, such as anxiety, depression, family conflicts, or alcohol use, during the past year. Fourteen percent or 32 respondents sought help. Among this group, twelve to fourteen people used the services of psychiatrist/psychologists, doctors, and social workers/counselors; no one sought advice from clergy or a support group.

Table 5.3
Types of Resources Contacted for Help with Emotional Problems (N=32)

	N	%
Psychiatrist/ Psychologist	14	43%
Doctor	12	38%
Social Worker/ Counselor	12	38%
Other	3	9%
Clergy	0	0
Support Group	0	0

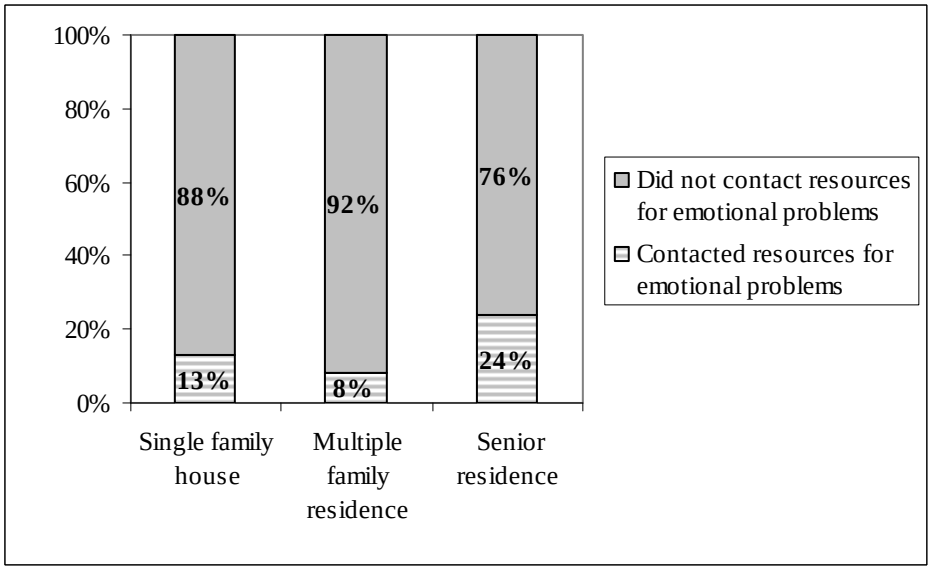
Among those contacting a resource for help with emotional problems, 25 contacted one resource, and 7 contacted two or three resources. One might have anticipated that sex and education would be related to reaching out for assistance, but that was not the case. Sex and education were unrelated to resource contact, as were age, marital status, living arrangements (living alone or with others), and disability. Depression was related to resource contact: respondents who were depressed were more likely to reach out for help than others (chi-sq =15.2, 2df, $p<.001$); 32 percent of those who were depressed contacted resources. However, what is most striking is that 68 percent did not reach out.

Figure 5.3
Resource Contact by Presence of Depression



Respondents living in senior residences were somewhat more likely to seek help for emotional problems than others (chi-sq = 8.3, 2df, $p<.05$). As seen earlier in Figure 2, a higher percentage of respondents who are depressed live in senior housing than in other types of residences. Senior residences in Brookline are staffed by part-time social workers, so help with emotional problems is more readily available for this group.

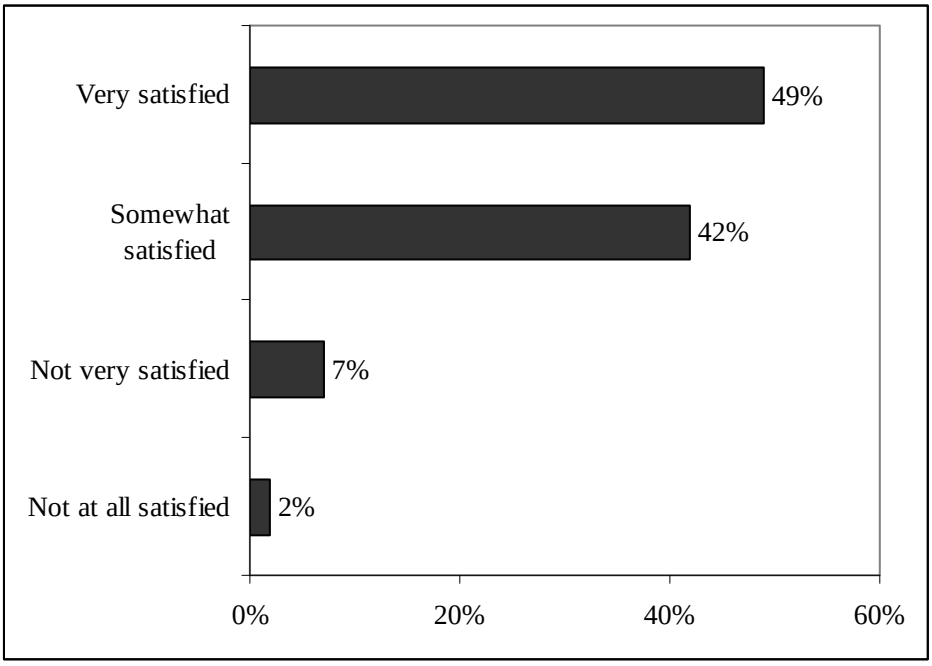
Figure 5.4
Resource Contact by Residence Type



5.7 Satisfaction

Respondents were asked, "All things considered, how satisfied are you with your life these days?" The answer choices were: "Very satisfied," "Somewhat satisfied," "Not very satisfied," "Not at all satisfied." As figure 4.5 shows, almost half said they were "Very satisfied," and combining the top two categories, 91 percent were either "Very" or "Somewhat satisfied." This pattern confirms other research about satisfaction and age. As reported recently in the New York Times, research discussed in the May 17, 2010 Proceedings of the National Academy of Science indicates that satisfaction levels are quite high at age 18, then decrease until age 50 when they start to rise. "By the time they are 85, (people) are even more satisfied with themselves than they were at 18."[15]

Figure 5.5
Overall Satisfaction With Life



Respondents who said they were "Not very" or "Not at all satisfied" were asked to explain their reasons. However, some people who were satisfied volunteered their reasons also. Examples of both positive and negative comments are seen below:

Satisfied

> *"I try not to think about the hereafter. I live day-to-day. I have no complaints. I feel lucky I can do what I want to do."*
>
> *"I have inoperable cancer, but am not limited in activities, although this might happen in the future. I'm very satisfied with life in spite of my prognosis."*
>
> *"I'm so lucky. I do the best I can."*

[15] Nicholas Bakalar, *Happiness May Come With Age, Study Says*, New York Times, May 31, 2010.

Not Satisfied

"My husband is very sick. He can't walk. I have to do everything. Taking care of my husband is a big problem. I can't leave him."

"I wish I had better health. I'm heavily restricted by these health problems."

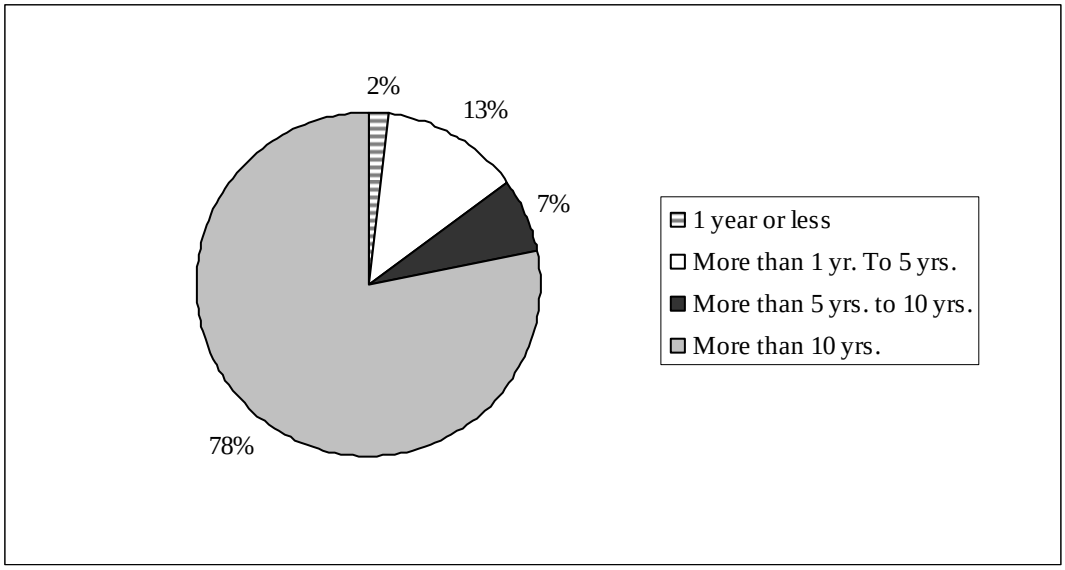
"I have physical limitations and pain. I've lost most of my family and friends. I have little energy and am unable to travel."

6.0 HOUSING

6.1 Length of Time in Brookline, Homeownership, and Thoughts about Moving

As people age, they are confronted with a variety of decisions about where to live that will affect their quality of life and independence. Should they remain in a home they have lived in for a number of years or move? If they choose to move, should they remain in the same community or move to another locale? If they remain in the same community, should they buy a condo or rent? Our respondents tended to be well-established in the town. The majority (78%) had lived in Brookline for more than ten years. Only 15 percent had lived here for five years or less. Almost half (45%) owned their own homes, and few (12%) were considering moving.

Figure 6.1 Length of Time in Brookline



Forty-five percent were home owners and 55 percent were renters.

- Men were more likely than women to own their home (58% vs. 40%, chi-sq = 6.12, 1df, p<.05).

- Homeowners were more likely to be in the younger age groups; 50 percent of people aged 85-89, 40 percent of people aged 90-94 and 3 percent of people aged 95+ were home owners (chi-sq = 7.76, 2df, p<.05).

- People with no disabilities were more likely to be home owners than people who were frail or severely disabled (no disability, 54%; frail, 37%; severely disabled 21%, chi-sq = 8.97, 2df, p<.05).

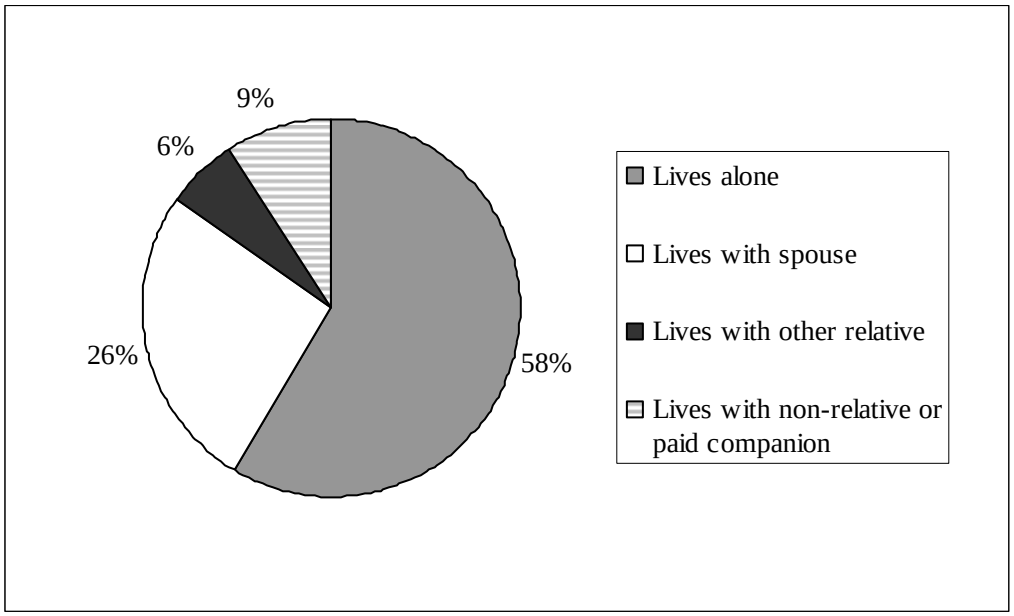
Home owners were more likely to think about moving than renters (20% vs. 6%, chi-sq = 9.37, 1df, p<.05), perhaps because renters were already living in environments that were more accommodating for the elderly (e.g., having elevators and/or having some home adaptations in senior living residences). Those who were living in a single family house

were more likely than those in a non-senior multiple family residence or those in a senior residence to think about moving (26% vs. 13% and 4%; chi-sq = 11.5, 2df, p<.01).

6.2 Living Group Arrangements

Fifty-eight percent lived alone, and 42 percent lived with others. Among those living with others, the majority lived with their spouse.

Figure 6.2 Living Group Arrangements



- Women were more likely than men to live alone (34% vs. 61%, chi-sq = 13.40, 1df, p<.001).

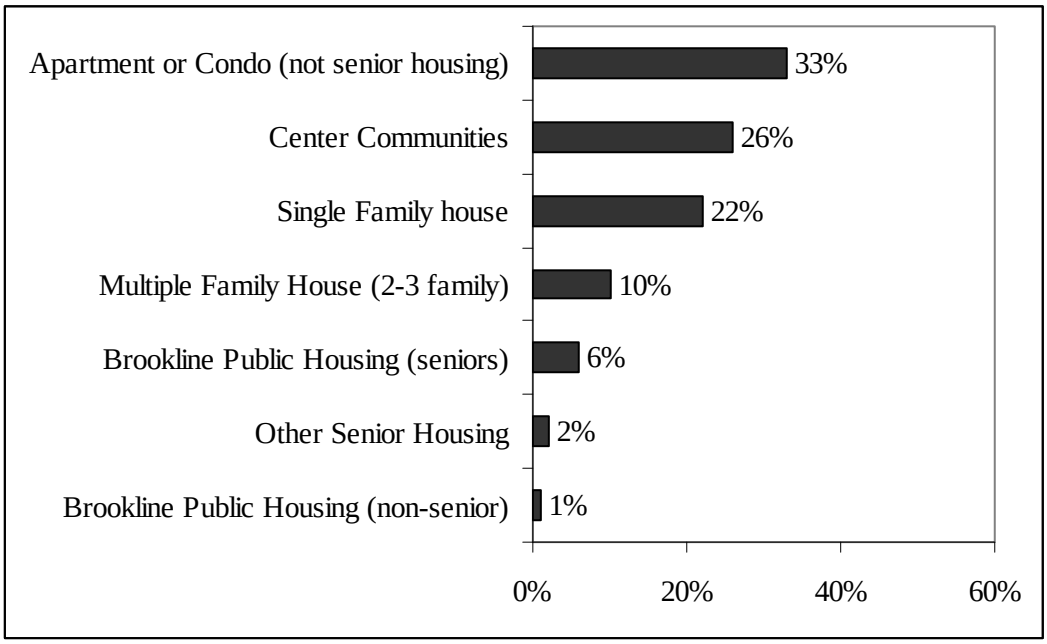
- Correspondingly, men were more likely than women to live with their spouse (90% vs. 58%, chi-sq. = 10.01, 1df, p<.01), which is not unexpected since women tend to live longer than men.

- Women were more apt than men to live with other relatives (26% vs. 8%, chi-sq = 4.41, 1df, p<.05).

6.3 Type of Residence

Approximately one-third of the respondents lived in an apartment or condo that was neither senior housing nor public housing; slightly over one quarter lived at Center Communities (3 senior housing residences that are not classified as assisted living although they provide some support services); and one-fifth lived in a single family house. The remainder lived in a two or three family house, Brookline Public Housing, or other senior housing.

Figure 6.3 Residence Type



The above seven housing categories were collapsed into three groups for ease of analysis:

Group 1 – senior housing, combined Center Communities, senior public housing and other senior housing (34%, N=76))
Group 2 – multiple family residence, combined two and three family houses, apartments or condos, and non-senior public housing (44%, N=97)
Group 3 – single family home (22%, N=48)

There were differences in patterns by housing types. Respondents who lived in senior housing residences were more likely than others to live alone, to be currently unmarried (widowed, divorced/separated, or never married), to be older, to be frail, and to have lived in Brookline for 10 years or less. Respondents who lived in single family houses were more likely to be married, to say their health was "excellent" or "very good," to have no disabilities, and to have lived in Brookline for more than 10 years. They were also less likely to have fallen within the year. The characteristics of respondents who lived in multiple family residences sometimes resembled those living in single family homes and sometimes their characteristics were midway between the other two groups. (See Table 6.1)

Table 6.1 Profile of Housing Types by Selected Characteristics

	Senior Housing	Multiple Family Residence	Single Family House
Male	20%	34%	35%
Female	80%	66%	65%
n.s., p<.10			
Currently Married	8%	34%	63%
Not Married	92%	66%	38%
chi-sq = 19.59, 2df, p<.001			
85-89 years	54%	79%	67%
90-94 years	28%	20%	29%
95 plus	18%	1%	4%
chi-sq = 23.51, 4df, p<.001			
Excellent/very good health	24%	36%	52%
Good health	40%	34%	27%
Fair/poor health	37%	30%	21%
chi-sq = 10.6, 4df, p<.05			
No Disability	40%	54%	69%
Frail - 2 ADL and 1 or more IADL	51%	39%	31%
Severe Disability - 3+ ADL	9%	7%	0%
chi-sq = 12.18, 4df, p<.05			
Lives Alone	83%	50%	38%
Lives With Others	17%	50%	63%
cChi-sq = 29.93, 2df, p<.001			
Lived in Brookline 10 years or less	42%	17%	4%
Lived in Brookline more than 10 years	58%	84%	96%
chi-sq = 27.9, 2df, p<.001			
Fell during the past year	41%	37%	21%
Did not fall during the past year	59%	63%	79%
chi-sq=5.7, 2df, p<.10			

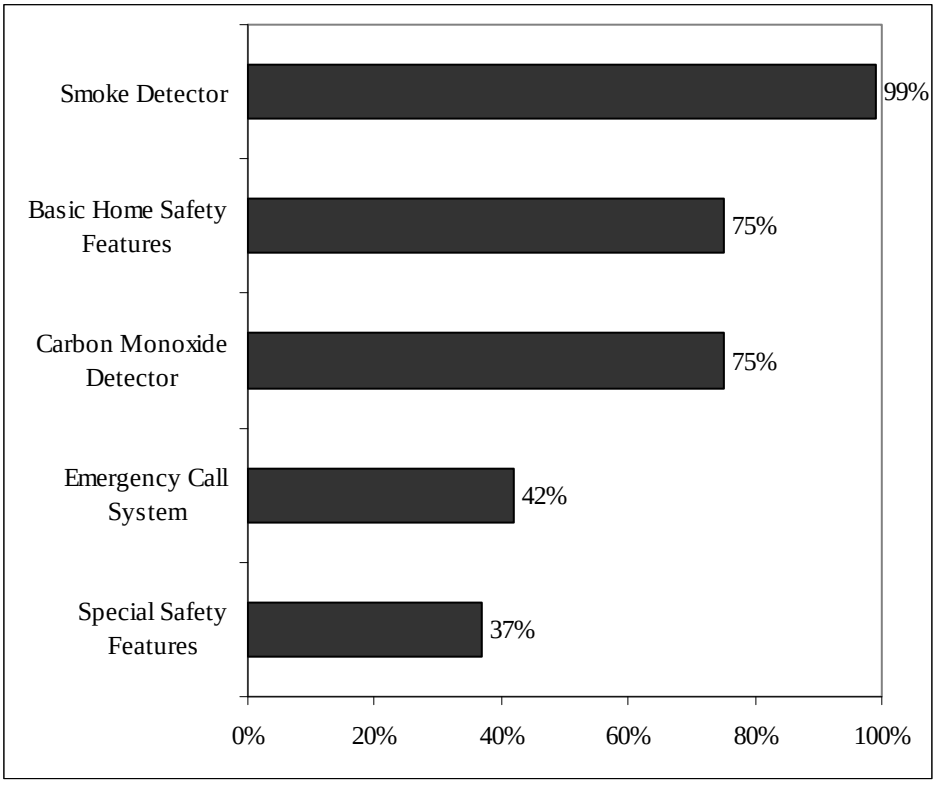
6.4 Home Safety Adaptations

Home safety adaptations help prevent accidents and enhance independence, and, thus, contribute to an elderly person's ability to live in his/her own home as long as possible. Respondents were asked about five types of home safety adaptations:

- Smoke detectors
- Carbon monoxide detectors
- Emergency call systems (worn around the neck, attached to a wall, or placed on a piece of furniture)
- Basic home safety features (e.g. a seat in the shower or tub, grab bars around the toilet, a raised toilet seat, etc.)
- Special home safety features (e.g. wider doorways or hallways, ramps leading to a street level entrance, railings, easy to open doors, accessible parking or drop-off site, special kitchen features, an elevator or chair lift, etc.).

Nearly all respondents had smoke detectors. Three-quarters had basic home safety features and carbon monoxide detectors. Approximately two-fifths had an emergency call system. A little over one-third had special safety features that made it easier for them to get around.

Figure 6.4 Presence of Home Safety Adaptations



Eighty-percent said the batteries in their smoke and carbon monoxide detectors had been changed during the past year; 7 percent said they had not been changed; and 13 percent were unsure. Six percent of those with no disability and more than 20 percent of those who were frail or severely disabled did not know whether the batteries had been changed.

As would be expected, emergency call systems, basic home safety features, and special safety features were more common among those living in senior housing residences than among those living in multiple family or single family residences.

Table 6.2 Home Safety Adaptations by Type of Residence

	Senior Housing	Multiple Family Residence	Single Family House
Emergency Call System	68%	25%	35%
No Emergency Call System	32%	75%	65%
chi-sq = 33.56, 2df, p<.001			
Basic Home Safety Features	93%	67%	62%
No Basic Home Safety Features	7%	33%	38%
chi-sq = 21.11, 2df, p<.001			
Special Safety Features	63%	21%	29%
No Special Safety Features	38%	78%	70%
chi-sq = 30.78, 2df, p<.001			

Women, people who were 95 and older, the severely disabled, and people living alone were more likely than others to have emergency call systems.

- Forty-eight percent of women compared to 28 percent of men had emergency call systems (chi-sq = 7.61, 1df, p<.01).

- Eighty-two percent of those aged 95 and older, 54 percent of those aged 90-94, and 33 percent of those aged 85-89 had emergency call systems (chi-sq = 19.3, 2df, p<.001).

- Eighty-six percent of those with a severe disability, 54 percent of those who were frail, and 27 percent of those with no disability had an emergency response system (chi-sq = 27.0, 2df, p<.001).

.

- Fifty-three percent of those who lived alone and 27 percent those who lived with others had emergency call systems (chi-sq = 14.4, 1df, p<.001).

The presence of basic home safety features and special home safety features increased along with level of disability. Sixty-three percent of those with no disability, 87 percent of the frail, and 100 percent of those with a severe disability had basic home safety features (chi-sq = 21.161. 2df, p<.001). In regard to special safety features, 31 percent of

those with no disability, 41 percent of the frail, and 57 percent of the severely disabled had special safety features (chi-sq = 4.7, 2df, p<.10). This pattern was not statistically significant, but it approached significance.

6.5 Pet Ownership

Some studies have shown that pet ownership has positive effects on the elderly, and the survey asked respondents whether they owned a dog or a cat. Seventeen percent owned a dog or a cat.

6.6 Concerns about Neighborhood Crime

Respondents were asked whether they had concerns about their physical safety in their neighborhood because of crime. Ten percent mentioned that neighborhood crime was a concern.

6.7 Housing-Related Service Needs and Pressing Concerns

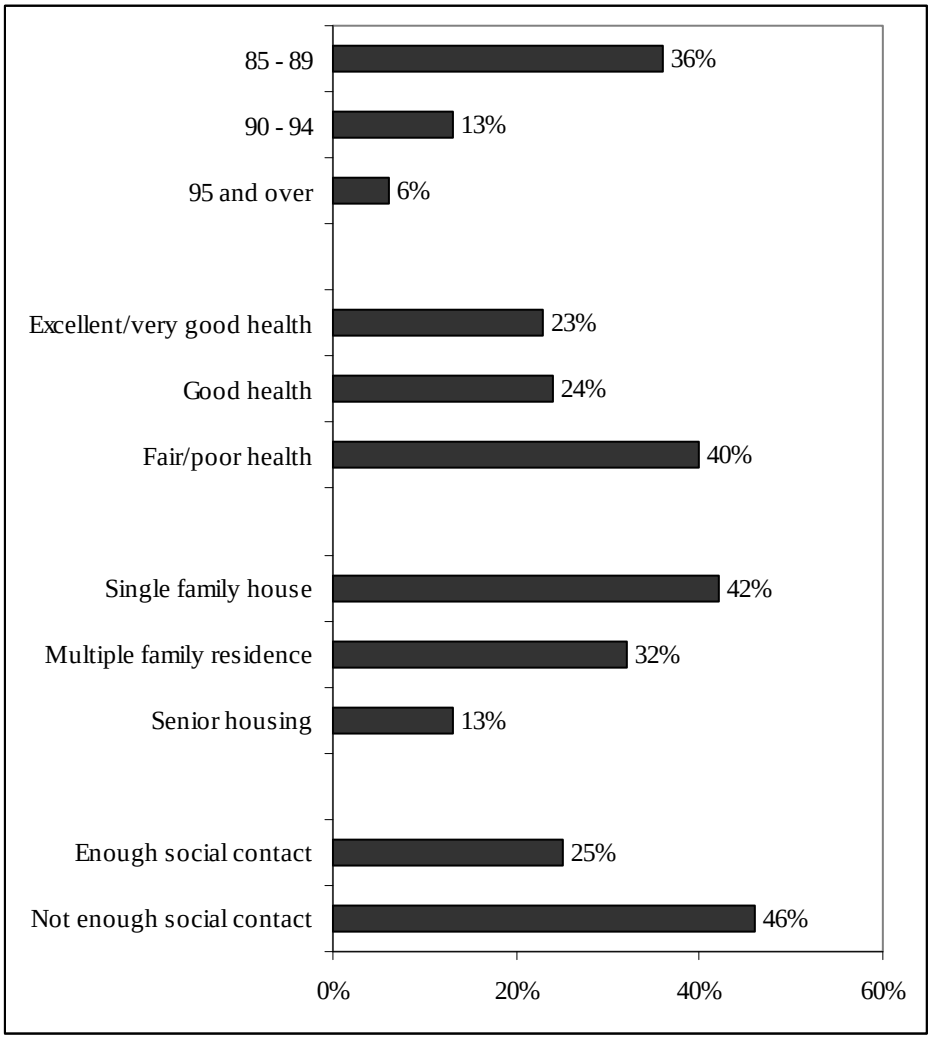
The survey asked respondents whether they needed any housing information or services. The list included 9 housing items. Twenty-eight percent had some housing needs. The most frequently mentioned need was for information about housing alternatives.

Table 6.3 Housing Needs (N=223)

	N	%
Housing alternatives (assisted living, senior housing, etc.)	29	13%
Emergency response system	21	9%
Help with yard work, snow shoveling, etc.	15	7%
Home repairs (home modifications, hand rails, grab bars, ramps, etc.	11	5%
Home safety features to prevent falls	12	5%
Public subsidized housing	9	4%
Help with selling or giving away furniture	9	4%
Neighborhood crime and personal safety concerns	4	2%
Help with downsizing (help to develop a plan to move to a smaller living space)	1	<1%
Total number of respondents with housing needs	**63**	**28%**

Housing needs were related to self-reported health status (chi-sq = 6.3, 2df, p<.05), residence type (chi-sq = 13.6, 2df, -<.001), age (chi-sq = 15.78, 2df, p<.001), and perceived adequacy of social contact (chi –sq = 6.4, 1df, p<.05). People who rated their health as "fair" or "poor," who lived in a single family house, who were in the 85-89 age group, and who perceived that their social contact was "not enough" were more likely than others to have questions or concerns about housing..

Figure 6.5
Percent with Housing Needs by Selected Characteristics



When asked about their most pressing concerns, 17 respondents mentioned housing:

<u>Concerns about home maintenance and home adaptations</u>

> *"The kitchen cabinets are so high that I need a step stool to reach some shelves."*
>
> *"I have a problem with clutter."*

"My house needs work."

"Keeping up the house. It's very expensive to heat."

"My husband died and I see myself as moving to an assisted living facility in 3-4 years. I need to get the house cleaned out. Need to go through my husband's papers, our library, and make decisions about disposing of his things."

"Our building is having problems. Can't open windows. Maintenance man does not do the job. No light in kitchen. Doors left open. We can't seem to get anyone to listen to us."

Concerns about moving

"Should I go to a facility and give up my freedom or stay here alone?"

"We're moving into an assisted living facility and we're experiencing the stresses involved in moving."

'I'm thinking about moving but I want my own place where I can prepare my own meals. My doctor says I need household help and an emergency response system."

"I'm concerned about moving to a (senior residence) in two months, but my family will help."

"In several years, I may consider moving to another kind of home if I become dependent. I do not consider being taken care of by my daughter-in-law."

Concerns about building security

"I'm concerned about safety in my building."

"I'm concerned about building security. There's no coverage from 4pm Friday til Monday morning."

"I have concerns about lack of security in the building."

Other housing related concerns

"My current living situation is very isolating."

"I'm having a conflict with the trustees of my condo complex and I feel disrespected."

"I live in housing for seniors and would like to have a live-in concierge or super in the building in case of need."

7.0 TRANSPORTATION

Access to transportation is a key element which helps seniors maintain their quality of life and their ability to age in place. Without access to transportation, it is difficult to keep important health care appointments, shop for necessities, and connect with family, friends and social activities. This section examines driving patterns and the use of transportation resources.

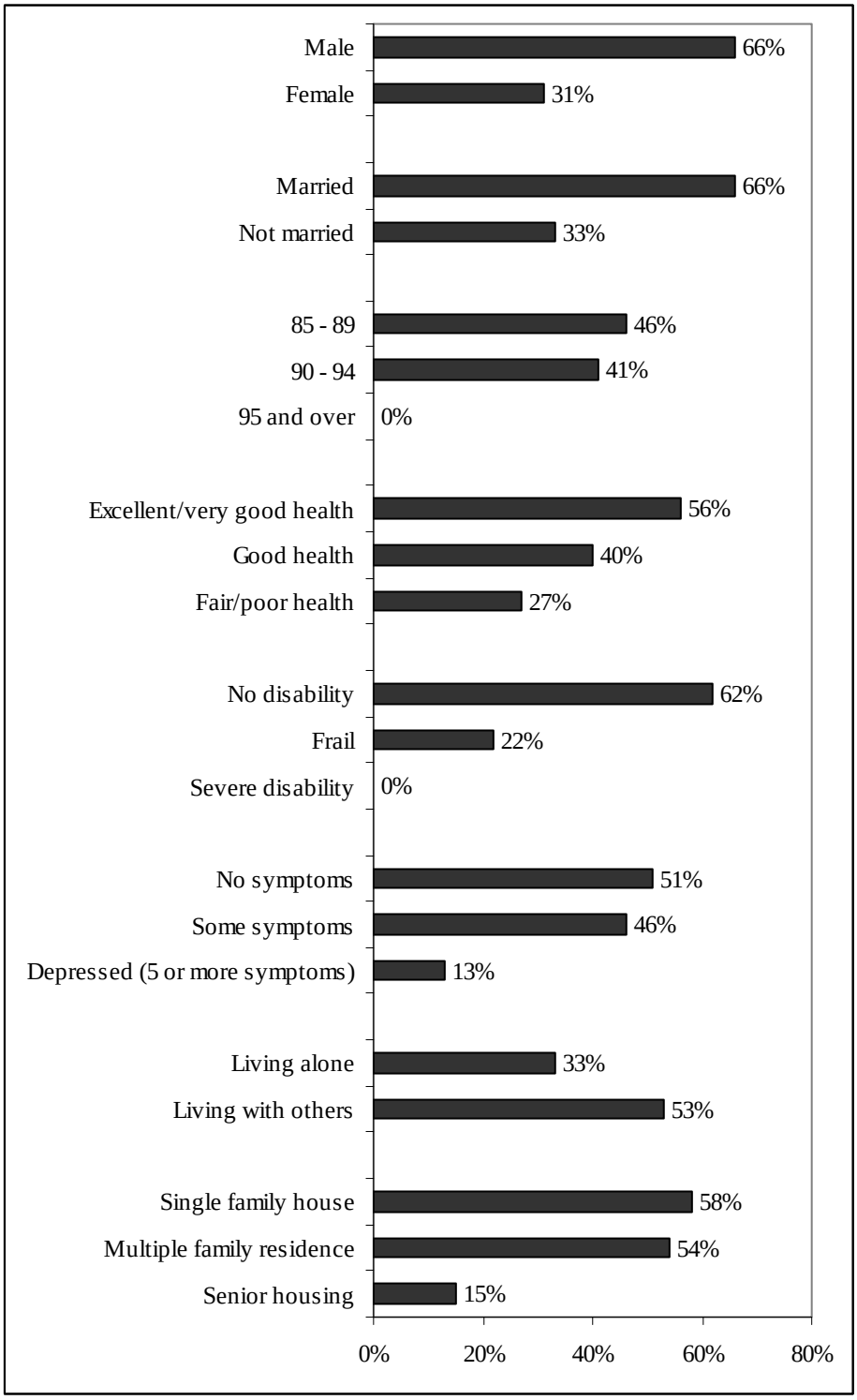
7.1 Driving Patterns

Respondents were asked whether they currently drive a car, and, if so, how frequently they drive. Forty-one percent (92) drive.[16] Among those who drive, 70 percent drive every day or almost every day; 22 percent drive once or twice a week; and 9 percent drive less than once a week. Driving is related to a variety of characteristics: age (chi-sq = 14.2, 2df, p<.001), sex (chi-sq = 23.5, 1df, p<.001)[17], marital status (chi-sq = 19.0, 1df, p<.001), self-perceived health status (chi-sq = 13.0, 2df, p<.001), disability status (chi-sq = 43.6, 2df, p<.001), symptoms of depression (chi-sq = 13.4, 2dr, p<.001), residence type (chi-sq = 34.4, 2df, p<.001), and living group type (chi-sq = 9.1, 1df, p<.01). Many of these characteristics are correlated. More men than women tend to be married, to consider their health to be excellent or very good, to have no disabilities, to have no depressive symptoms, etc., and, thus, they are more likely to be drivers.

[16] N.M. Silverstein & Bei Wu. *A Snapshot in the Lives of Community-Residing Elders 85 and Older: Their Lifestyles, Contributions, and Concerns*, Gerontology Institute and Center, University of Massachusetts. Boston (1997). This study found that 43% were still driving.

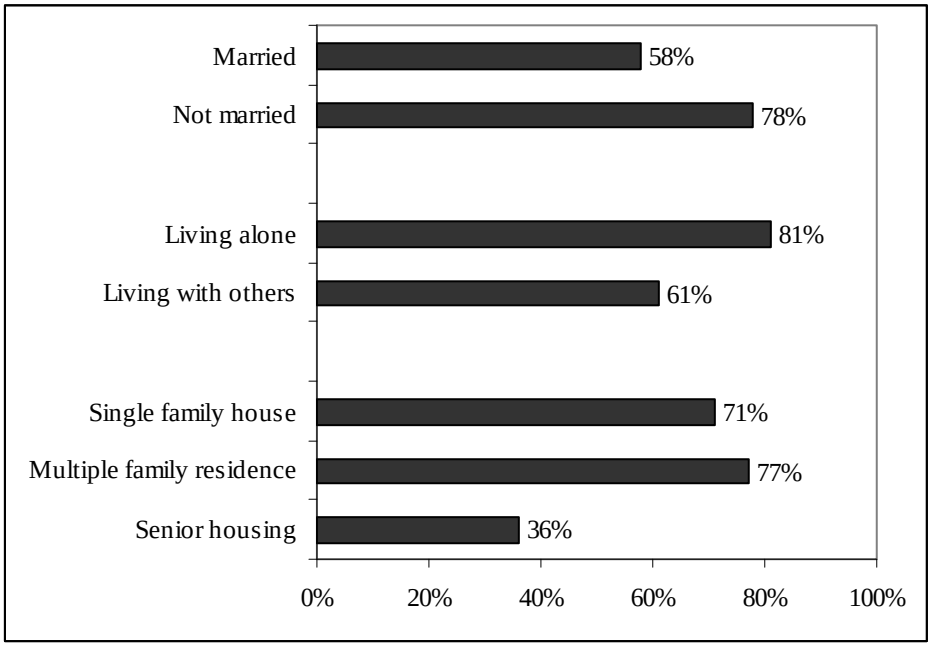
[17] National Institute on Aging. The Health and Retirement *Study: Growing Older in America: 2002* found similar differences between men and women in driving patterns – 32% of the men and 66% of the women in the 85+ group were not driving, Ch. 1, p. 33, Fig. 1-11. <www.hrsonline.isr.umich.edu/sitedocs/databook/HRS_Text_WEB_Ch1.pdf>.

Figure 7.1
Percent Who Drive by Selected Characteristics (N=92)



People who drive every day or almost every day (70% of the drivers) are more likely to be those who are not married (chi-sq = 4.2, 1df, p<.05), who live alone (chi-sq = 4.2, 1df, p<.05), and who live either in multiple family or single family residences (chi-sq = 7.2, 2df, p<.05). This pattern differs somewhat from the pattern seen in Figure 7.1. Frequency of driving could be related to a desire for social interaction. It could also be related to the lack of a support system to assist with routine errands or the lack of knowledge about other transportation alternatives.

Figure 7.2
Percent Who Drive Everyday or Almost Every Day
by Selected Characteristics



Respondents were asked whether they limit their driving for any reason, such as preferring not to drive at night, on highways, in bad weather, or for long distances (defined as one hour or more). Sixty-two percent of those who drive engage in some type of self-regulation. No respondents in the 95 and older group were still driving. Respondents in the 90-94 age group were more likely than those in the 85-89 age group to limit their driving activities (91% vs. 51%, chi-sq = 11.0, 1df, p<.001). Women were more likely to limit their driving than men (78% vs. 42%, chi-sq = 12.2, 1df, p<.001).

7.2 Modes of Transportation

Respondents were asked about the types of transportation they used, aside from cars. Transportation from family, friends or neighbors was the most frequently mentioned, followed by regular taxis, the MBTA "The Ride," and public transportation.

Figure 7.3
Modes of Transportation

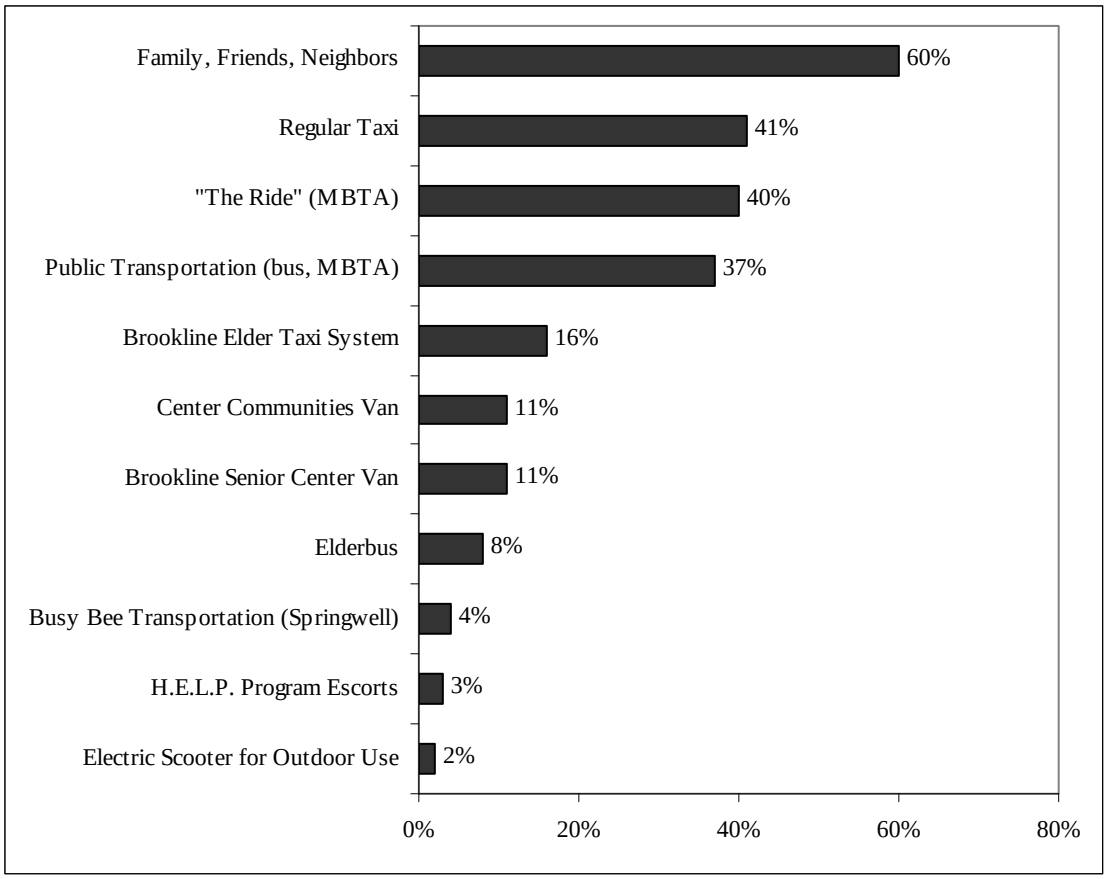


Table 7.1 compares transportation modes by selected respondent characteristics. Public transportation tended to be used more frequently by men, by those without a disability, and by those without a walking problem. “The Ride” tended to be used more frequently by women, by those who were depressed, and by those living in senior residences -- characteristics which are highly correlated with one another.

Table 7.1 A Comparison of Transportation Modes by Selected Characteristics

	Drives Car	Family/Friends/Neighbors	Taxi	Public Transp.	"The Ride"
Age	chi-sq = 14.2, 2df , p<.001	n.s.	n.s.	n.s.	n.s.
85-89	46%	60%	41%	40%	36%
90-94	41%	56%	44%	37%	51%
95 and over	0%	67%	35%	17%	44%
Sex	chi-sq = 23.5, 1df, p<.001	n.s.	n.s.	chi-sq=4.9, 1df, p<.05	Fisher's Exact Test = 15.4, p<.001
Male	66%	52%	38%	48%	20%
Female	31%	63%	43%	33%	48%
Walking Problem	n.s.	n.s.	n.s.	chi-sq = 12.6, 1df, p<.001	n.s.
Yes	28%	63%	52%	20%	51%
No	38%	63%	39%	48%	34%
Disability Status	chi-sq = 43.6, 2df, p<.001	n.s.	n.s.	chi-sq = 27.9, 2df, p<.001	n.s.
No disability	62%	51%	37%	54%	33%
Frail	22%	67%	45%	20%	48%
Severe disability	0%	71%	50%	14%	43%
Depression	chi-sq = 13.4, 2df, p<.001	n.s.	n.s.	n.s.	Fisher's Exact Test = 9.1, p<.05
No symptoms	51%	60%	41%	40%	30%
Some symptoms	46%	61%	43%	37%	41%
Depression	13%	47%	36%	32%	61%

Residence Type	chi-sq = 34.4, 2df, p<.001	n.s.	n.s.	n.s.	Fisher's Exact Test = 29.1. p<.001
Single family house	58%	62%	44%	33%	22%
Multiple family res.	54%	58%	45%	40%	30%
Senior housing	15%	61%	33%	37%	64%

7.3 Familiarity with Transportation Modes

The survey asked respondents about their familiarity with various transportation types of transportation. Approximately one-fifth (22%) indicated a lack of familiarity with the H.E.L.P. Program Escorts, a program that is run by the Brookline Council on Aging. Fifteen percent lacked familiarity with Springwell's Busy Bee Transportation.

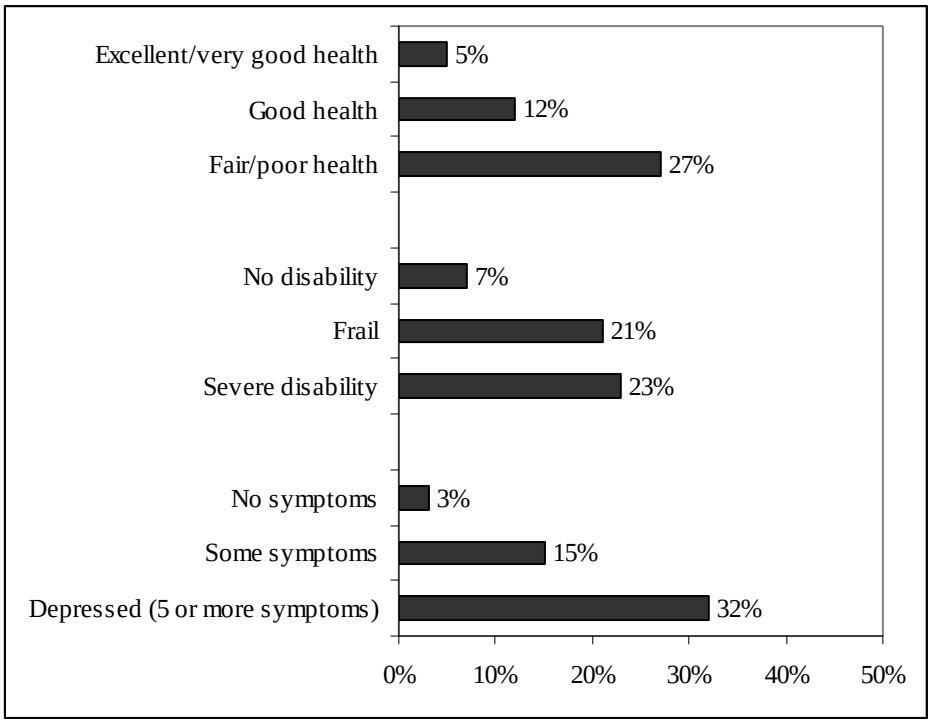
Table 7.2
Percent Indicating Lack of Familiarity with Transportation Resources

	N	%
H.E.L.P. Program Escorts (n= 48)	48	22%
Busy Bee Transportation (Springwell) (n=33)	33	15%
Brookline Elder Taxi System (BETS) (n=15)	15	7%
Elderbus (n=13)	13	6%
Center Communities Van (n=14)	14	6%
Brookline Senior Center Van (n=7)	7	3%
"The Ride" (MBTA) (n=5)	5	2%
Electric Scooter for Outdoor Use (n=3)	3	1%

7.4 Transportation Problems

Respondents were asked whether they had problems finding people who could act as escorts and whether they had other transportation problems. Twelve percent (26) had problems finding escorts and 6 percent (13) had other transportation problems. In all, 14 percent or 31 people answered "yes" to one or both of these questions. Transportation problems were related to self-perceived health status (chi-sq = 14.3, 2df, $p<.001$), disability status (chi-sq = 9.3, 2df, $p<.01$), and depression (chi-sq = 15.6, 2df, $p<.001$).

Figure 7.4
Percent Reporting Transportation Problems
By Selected Characteristics (N=31)



7.5 Transportation Needs and Concerns

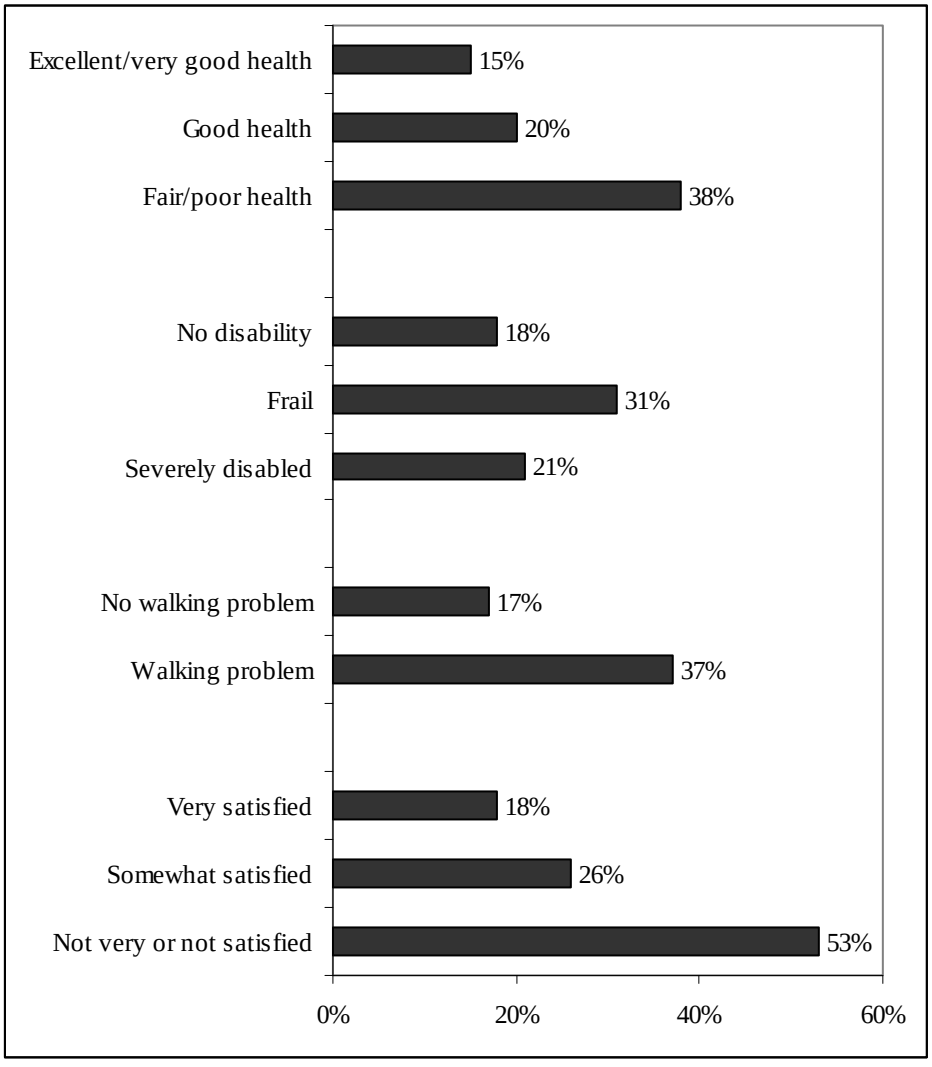
In addition to asking respondents an open-ended question about transportation problems they may have encountered, the survey asked about transportation needs. Twenty-four percent needed some transportation information or services. The questionnaire included 5 items about transportation needs. The two most frequently mentioned needs were: information about transportation alternatives and how to apply for transportation services.

Table 7.3 Transportation Needs (N=223)

	N	%
Transportation alternatives	41	18%
How to apply for transportation services	39	17%
Need transp to important appointments (e.g., medical appts., etc.)	17	8%
Programs that assess driving skills	3	1%
Driving safety concerns	1	<1%
Total number of respondents with transportation needs	**53**	**24%**

Transportation needs were related to self-reported health status (chi-sq = 11.7, 2df, p<.01) and having walking problems (chi-sq = 6.5, 1df, p<.05). People who perceived their health was "fair" or "poor" and those who had walking problems were more likely than others to report transportation needs. When we look at disability status, people who were frail (31%) had more transportation needs than people who were severely disabled (21%) and those who had no disability (18%). This pattern was not statistically significant but it approached significance (chi-sq. = 4.6, 2df, p<.10). Perhaps this pattern is due to the fact that severely disabled people may have an established support system which provides them with basic services in their own home, while those who are frail may lack an established support system. Transportation needs were unrelated to "often" feeling lonely or to feeling that social contact was "not enough." However, transportation needs were related to satisfaction. People who were "Not very" or "Not at all satisfied" were more likely to have transportation needs than those who were "Somewhat" or "Very satisfied" (chi-sq = 11.1, 2df, p<.01).

Figure 7.5
Percent with Transportation Needs by Selected Characteristics



In response to an open-ended question about pressing concerns, 18 percent or 42 people commented on transportation concerns:

Difficulty finding escorts:

"I need an escort for shopping assistance."

"I have to hire someone to drive and act as an escort."

"When my son is away, I have no way to get to medical appointments."

"I have trouble finding people to act as escorts."

"Escort services aren't available."

"I need to find people who can accompany me."

"I'd like to know about escorts, not only for visits to doctors, but to walk outside on nice days."

"I'd like to know about the availability of a driver to transport me to and from activities and appointments."

"Many activities are offered in Brookline, but it's not always easy to take advantage of them because of the lack of escort services."

"I don't go to the dentist since I can't get up the dentist's stairs. My son can't always take me."

Lack of knowledge about transportation options:

"I lack knowledge of transportation services."

"I need to investigate transportation options."

"I depend on my wife to drive. I'd like to find other transportation options."

"I'd like more information about Brookline Elder Taxi System."

"Would like information about emergency transportation services."

The cost of transportation services:

"There shouldn't be any barriers to allowing seniors to have access to "The Ride."

"Seniors shouldn't have any financial requirements with regard to transportation."

'We need more senior discounts for transportation".

"Transportation cost is a problem."

"It's expensive."

Problems with specific transportation modes:

"It's hard to access "The Ride."

"I have problems arranging transportation. "The Ride" is difficult to access."

"I have problems getting onto the bus because the step is too high."

"Taxi service doesn't like to take people on short trips. Taxi companies should be more solicitous of seniors and their needs."

"I'm in good health, but I find getting on and off the 'T' very difficult – the steps are too high to navigate easily."

"It's very difficult to get on public transit because the step is too high."

Transportation is unavailable on less than 24 hour notice:

"It's difficult to get a ride to places at the last minute. I need to plan ahead and sometimes that's not possible."

"Would like someone to take me to CVS shopping on the spur of the minute."

"Transportation should be more readily available."

Specific neighborhood-related transportation concerns:

"At a busy intersection near my house where there are traffic lights (Coolidge Corner and Harvard St.), cars go when the walk light is on. It's very upsetting."

"There's little public transportation where I live."

"We need better transportation services where I live, not only for myself but for my helpers."

"The traffic signals don't stay on long enough for walkers.

Disability makes going outside the home difficult:

"I don't feel secure going out of my home."

"My vision – I have macular degeneration – makes it difficult for me to go places."

"I can't drive and lack independence."

"I have vision problems, and can't get to see MDs easily."

Transportation to specific locations:

"I can't get to the theater."

"I need transportation to the library."

"We need better local transportation to the libraries"

"Stopped volunteering because of transportation problems."

"Can't get to CVS. CVS should deliver medications to people with problems getting out"

Concerns about getting out during bad weather:

"Concerned about how I will manage in the bad weather."

8.0 SOCIAL FUNCTIONING

This study looked at a specific aspect of social functioning, namely social connectedness. We focused on this topic since research about the elderly has shown that social networks decrease in density and frequency over time. Consequently, isolation is a prominent issue for the elderly and can lead to poorer health, mortality, depression, and cognitive decline. Both the objective and subjective aspects of social connectedness were examined. Questions about the objective aspect inquired about the presence of nearby family; the frequency of communication with family, friends, and neighbors; whether people used computers to contact relatives and friends; whether they had check-up systems; whether they had confidants; and frequency of activity participation. The subjective aspect was examined by looking at respondents' self perceptions: whether they felt their communication with relatives, friends, or neighbors was "enough" and whether they "often" felt lonely.

8.1 The Objective Reality of Social Connectedness

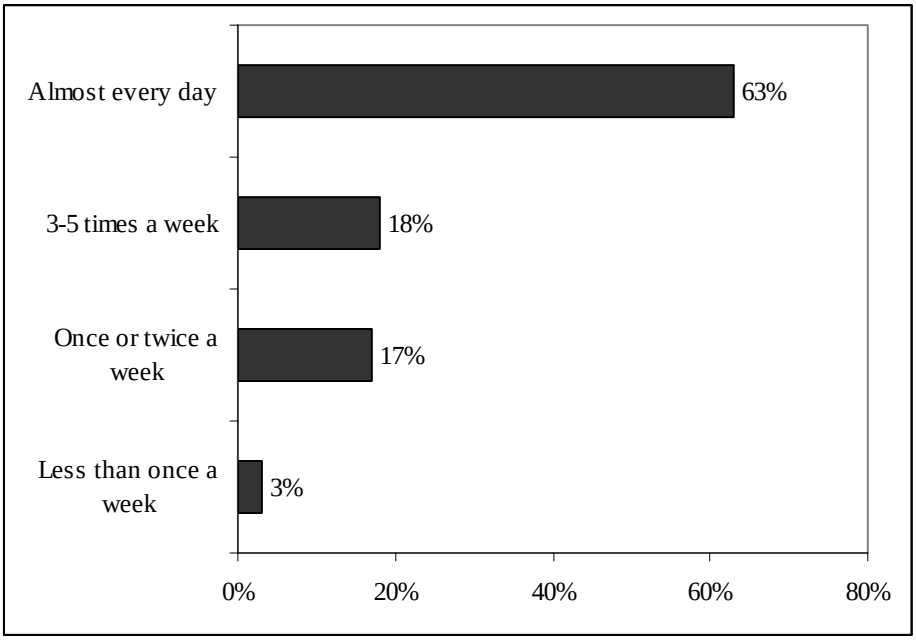
8.1.1 Presence of Family Nearby

Three quarters (76%) had family living nearby -- less than 30 minutes away. People living in Brookline 10 years or less were more likely than those living in Brookline for more than ten years to have family living nearby (90% vs. 71%, chi-sq = 7.29, 1df, $p<.01$). This may be due to the fact that many older people who move to a new community relocate to be closer to children or other relatives.

8.1.2 Communication with Family, Friends, and Neighbors

Slightly more than three-fifths (63%) of the respondents talked with family members, friends, or neighbors either in person or by telephone almost every day; 18 percent had contact 3-5 times a week; 17 percent had contact once or twice a week; and 3 percent had contact less than once a week. Frequency of communication was unrelated to characteristics such as age, sex, self-perceptions of health, disability status, depression, living group arrangement, residence type, and whether people drive. It was also unrelated to subjective measures of social connectedness -- loneliness and perceptions about adequacy of communication with relatives or friends.

Figure 8.1
Frequency of Communication with Family/Friends/Neighbors



8.1.3 Use of Computers

We wondered whether people used computers to communicate with relatives or friends since there is an assumption that older people, particularly those 85 and older, are not computer literate. Thirty-five percent (77 people) had a computer which they used to keep in touch with family and friends. Our data are somewhat comparable to data collected by the Pew Research Center which indicated that 27 percent of people aged 76 and older used computers online.[18]

- Sex (chi-sq = 22.9, 1df, p<.001), marital status (chi-sq=14.5, 1df, p<.001), education (chi-sq=36.4, 2df, p<.001), and residence type (chi-sq= 14.3, 2df, p<.001) were related to computer usage. Many of these characteristics are inter-related. Men are more likely than women to use a computer. They are also more likely than women to be married (55% vs. 14%, chi-sq = 41.1, 1df, p <.001), and to have higher levels of education (chi-sq = 24.4, 2df, p<.001).

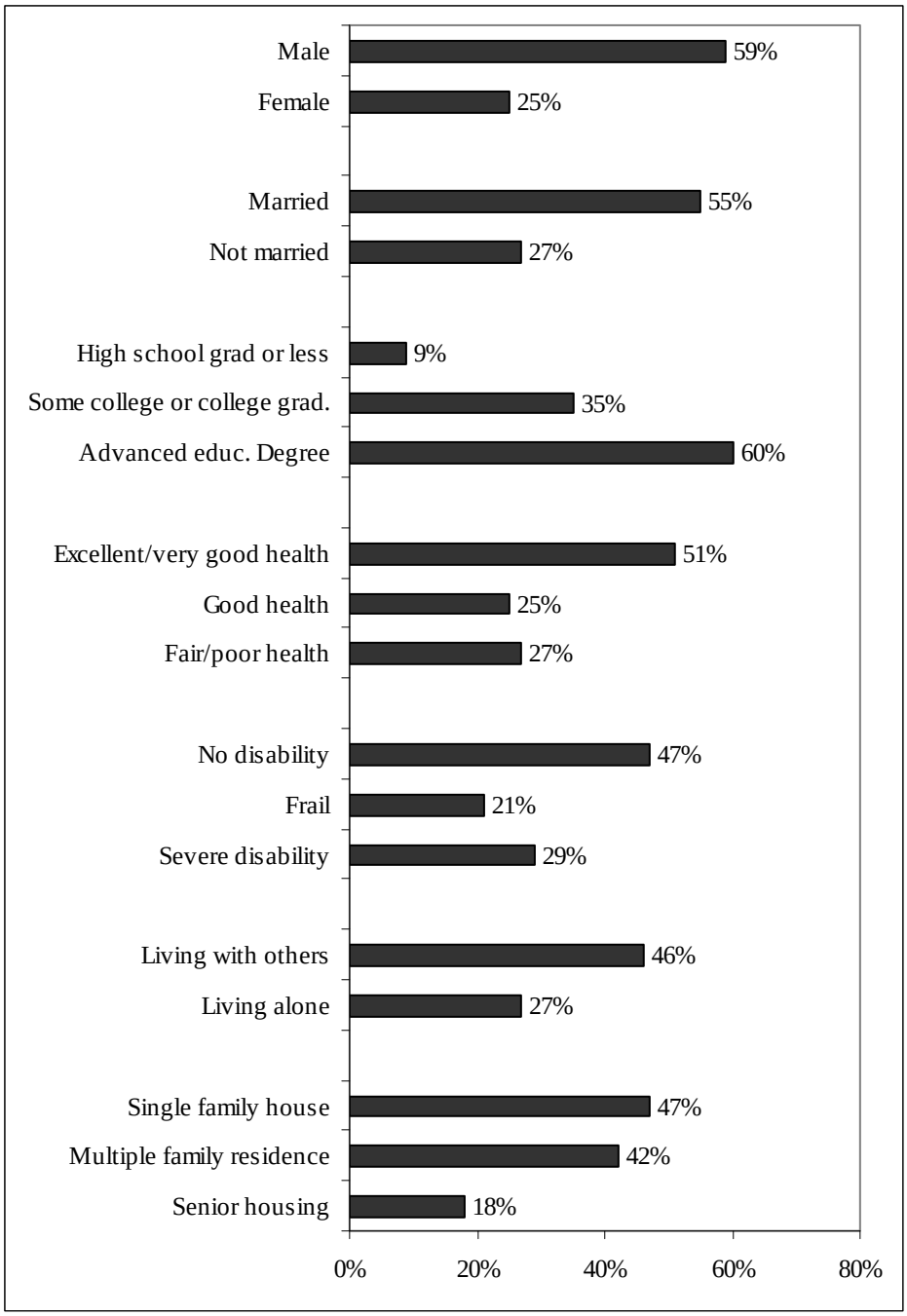
- Self-perceptions of health (chi-sq=13.8, 2df, p<.001) and disability status (chi-sq = 14.7, 2df, p<.001) were also related to computer usage. People who perceived themselves to be in "excellent" or "very good" health and who did not have any ADL or IADL limitations were more likely to be computer users. Here again, the reason for these patterns may be due to the fact that men, who are more frequent computer users, tend to be in better health than women.

- Looking at patterns of computer usage by education and sex in more detail reveals the following: at the lowest educational level (high school graduate or less than high school

[18] Data from the Pew Internet and American Life Project indicated that 27% of adults 76+ used computers online (Chart: Percentage of Americans Online by Age, Dec. 2008). From Shari Gershenfeld, *Home is Where the Heart Monitor Is* (Capstone Research Paper for University of Massachusetts Gerontology Program, Nov. 13, 2009).

graduate), there are no differences between men and women (9% use computers). Among those who are colleges graduates or have some college training, 58 percent of the men and 29 percent of the women use computers, and among those with advanced degrees, 74 percent of the men and 44 percent of the women use computers. These differences will probably change over time.

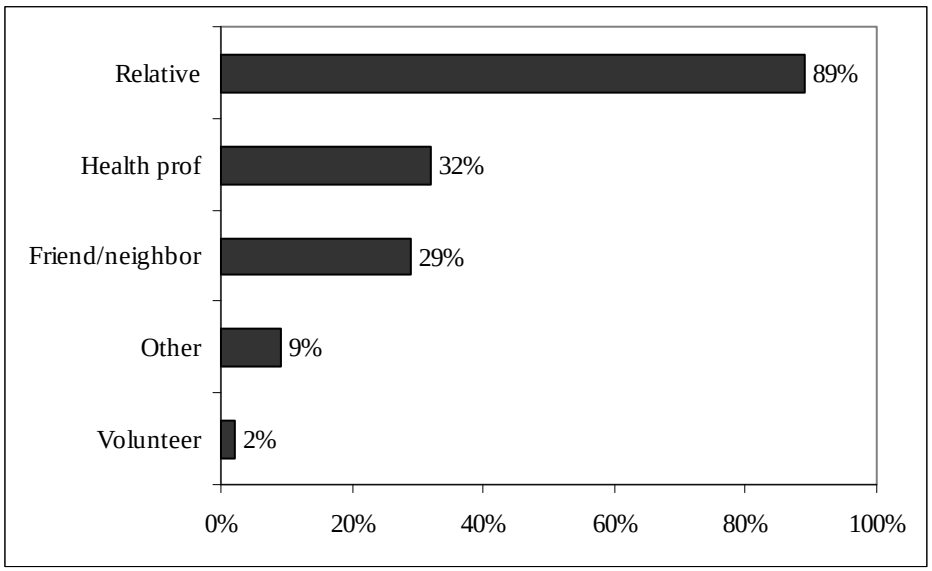
Figure 8.2
Percent Using Computers to Stay in Touch with People by Selected Characteristics



8.1.4 Confidants

Respondents were asked if they had confidants, people they to talk to if they have a problem or an important decision to make. Nearly all (94%) had people they could talk to about problems or important decisions; 6 percent had no one. Relatives were the most frequent choice (mentioned by 89%), followed by health professionals (doctors, social workers, nurses) and friends or neighbors. The category "others" included people such as lawyers, clergy, live-in companions, and home health aides.

Figure 8.3 Types of Confidants



8.1.5 Formal or Informal Check-up Systems

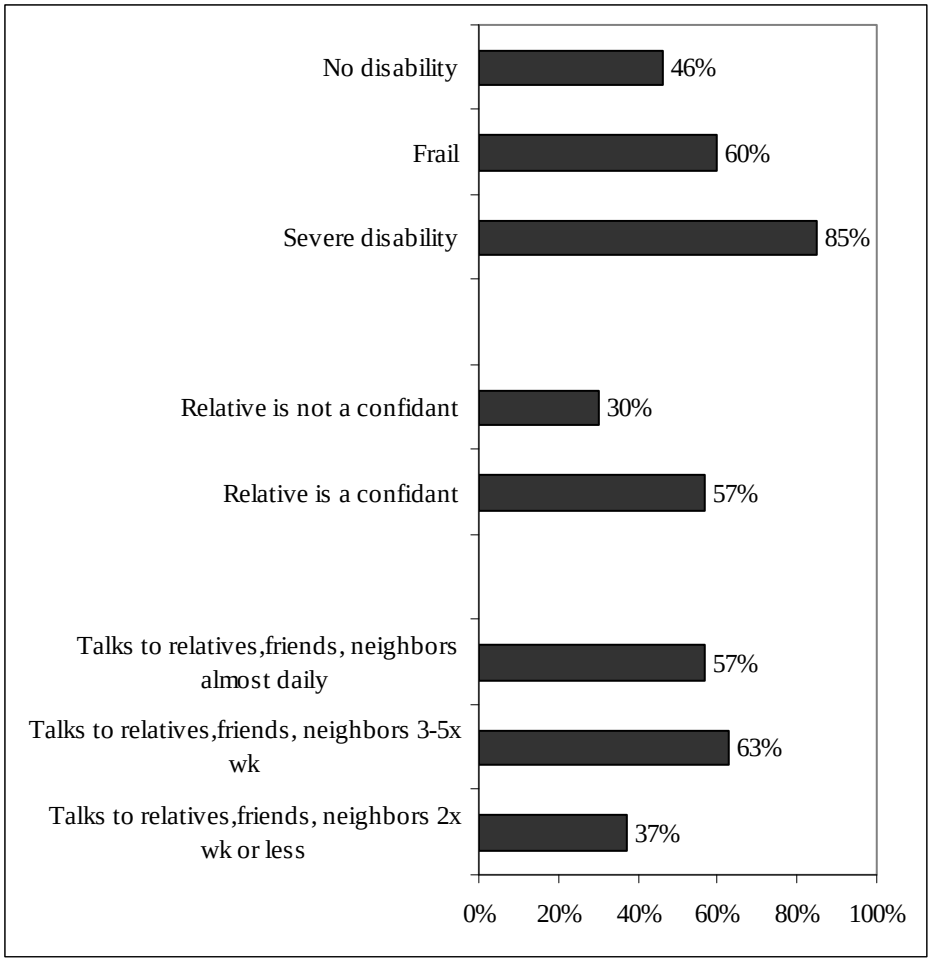
As people get older, they may like the reassurance of knowing that someone checks up on them on a regular basis. Respondents were asked if they had a formal or informal system whereby someone checks up on them or they check up on someone else. Over half (54%) had a check-up system.

- Check-up systems were related to disability status: the higher the level of impairment, the more likely that people had check-up systems (chi-sq = 9.0, 2df, $p<.05$); there was no relationship to age.

- Check-up systems were also related to frequency of communication with relatives, friends, and neighbors (chi-sq = 6.4, 2df, $p<.05$) and whether people identified a relative as a confidant (chi-sq = 6.0, 1df, $p<.05$). People who communicated with relatives, friends, or neighbors 3 times a week or more and people whose confidants were relatives were more likely to have check-up systems than those with lower levels of communication and those whose confidants were not relatives.

- Check-up systems were unrelated to the objective circumstances of living alone and/or not being currently married. One might have expected the reverse to be the case.

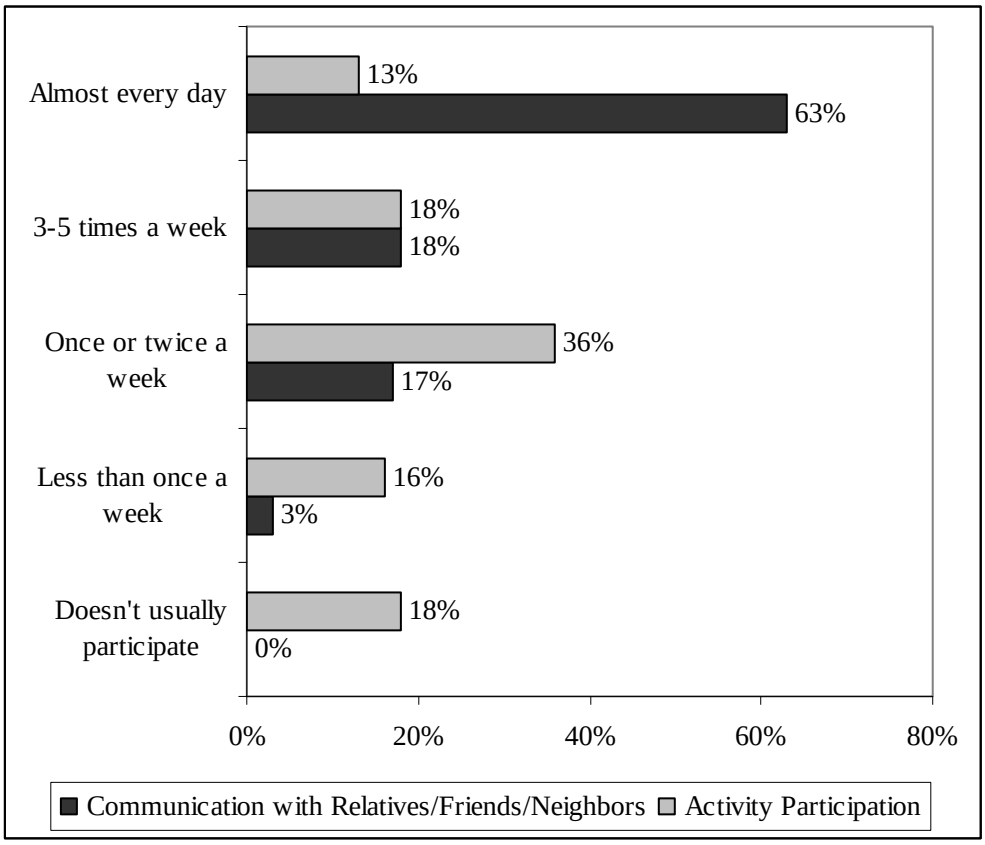
Figure 8.4
Percent with Formal or Informal Check-up Systems
by Selected Characteristics



8.1.6 Activity Participation

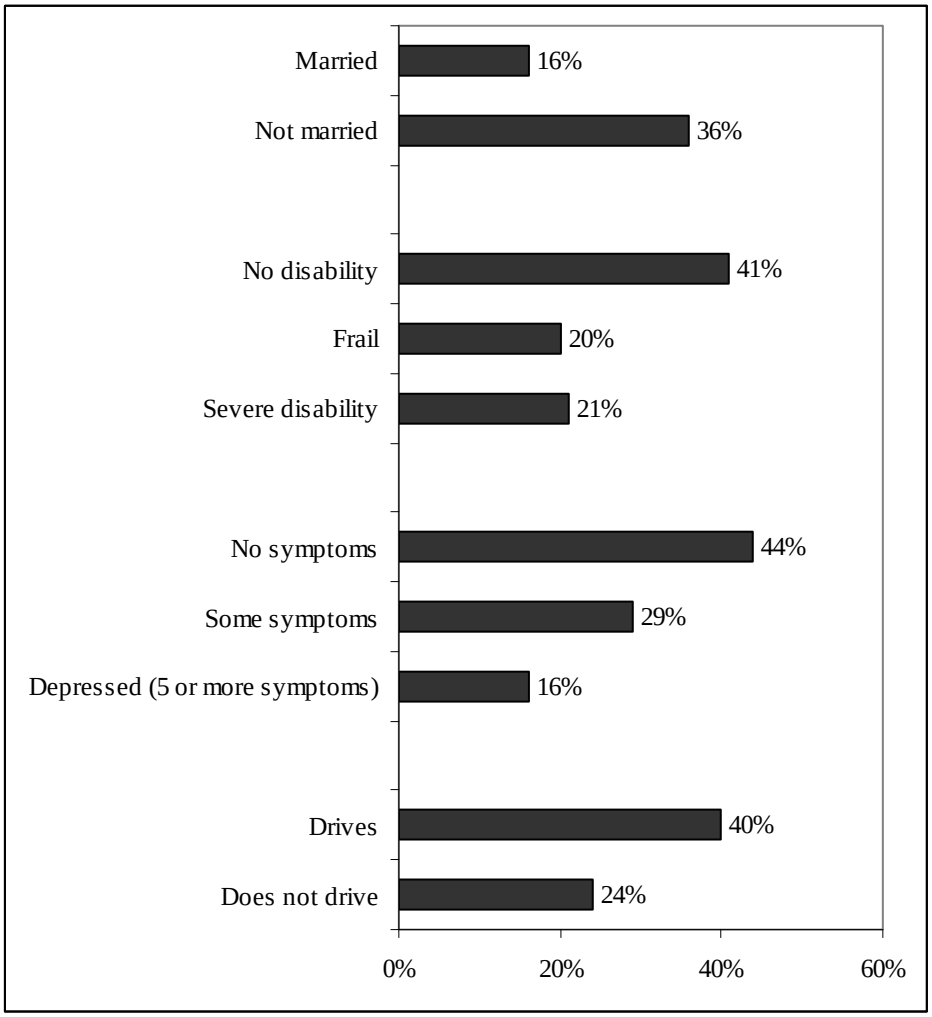
Respondents were asked about their activity participation outside the home (such as visiting friends or relatives, attending religious services or activities, volunteering, or going to movies, concerts, or restaurants) when weather *was not* an issue. Eighteen percent do not usually participate in activities outside their home; 16 percent participate less than once a week; 36 percent participate once or twice a week; 18 percent participate 3-5 times a week; and 13 percent participate almost every day. This pattern of activity participation is in sharp contrast to the pattern of communication with relatives, friends or neighbors seen earlier. Here, the most frequent response was "almost every day," mentioned by 63 percent, while the least frequent response was less than once a week, mentioned by 3 percent.

Figure 8.5
Frequency of Activity Participation Outside the Home Compared with Frequency of Communication with Relatives/Friends/Neighbors



- Frequency of activity participation was related to marital status (chi-sq = 11.0, 2df, p<.01), disability status (chi-sq = 16.8, 4df, p<.01), depression (chi-sq = 10.1, 4df, p<.05), and whether a person drives (chi-sq = 10.4, 2df, p<.01). People who were not married, who were in good health (e.g., had no disability and no symptoms of depression), and who were still driving were more likely than others to be socially active outside their home (went out 3 times a week or more). Interestingly, there was no relationship between frequency of activity participation and frequency of communication.

Figure 8.6
Percent Who Went out Socially Three Times a Week or More by Selected Characteristics



8.1.7 Caretaking

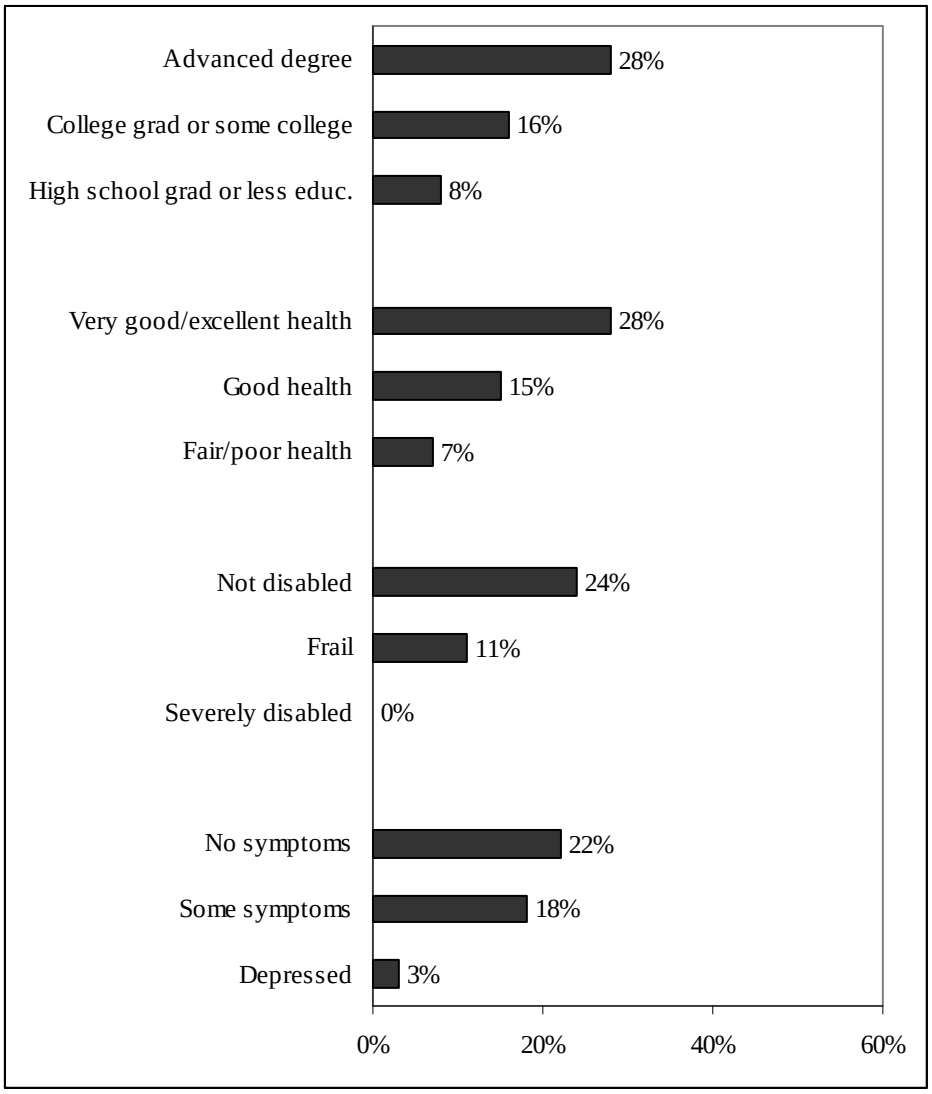
Respondents were asked about caretaking responsibilities -- whether they were currently assisting or arranging services for people who were sick or disabled and needed care. Nineteen (9%) were caring for others. Among these 19, 10 were caring for a spouse; 3 were caring for another relative; and 6 were caring for a friend or neighbor. Twelve people were caring for someone in their own home. Ten of the 12 people caring for someone in their home had help with their caretaking activities; 2 of the 7 people who had caretaking responsibilities outside their home had help. Seventeen of the 19 were 85-89, one was 90-94, and one was 95 and over. Eight caretakers were women, and 11 were men.

8.1.8 Selected Activities

Respondents were asked if they receive the Brookline Senior Center/ Council on Aging newsletter and if, during the past month, they participated in Brookline Senior Center activities. Nearly half (49%) receive the newsletter and one-fifth (22%) participated in Senior Center activities during the past month. Eight percent (17 people) are still working; and nearly all (93%) voted in the November 2008 presidential election.

The interview asked about formal volunteering activities for an organization. Seventeen percent (38 people) participate in formal volunteer activities. This probably underestimates the amount of volunteering that takes places since it is likely that quite a bit of informal volunteering takes place. During the interviews, some respondents mentioned the following activities. One woman who used to do formal volunteering for the Commission for the Blind now reads to a blind woman in her building. Another woman spends time every day with a close friend who has Alzheimer's. One man regularly volunteers to help people in his building with their small repairs; his business is thriving. Participation in volunteer activities is significantly related to education (chi-sq = 10.1, 2df, $p<.01$), self-reported health status (chi-sq = 11.4, 2df, $p<.01$), and disability status (chi-sq = 9.9, 2df, $p<.01$). There is a weak relationship with depression (chi-sq = 5.5, 2df, $p<.10$).

Figure 8.7
Percent Who Volunteer by Selected Characteristics



8.2 The Subjective Reality of Social Connectedness

8.2.1 Whether Social Contact was Sufficient

We asked respondents whether the amount of communication they had with relatives, friends, and neighbors was "not enough," "enough," or "too much," 84 percent said it was "enough" and 16 percent said it was "not enough." No one said it was "too much." There was no statistically significant relationship between the perceived adequacy of social contact and frequency of communication with relatives, friends, or neighbors. Thus, people who had a low level of communication (communicated with friends or relatives twice a week or less) were as likely as people who had a high level of communication (communicated with people three times a week or more) to say their social interaction was "enough."

- The perception that contact was adequate varied by disability and mental health status. The severely disabled were less likely than the frail or those with no disability to say it was "enough," (64% vs. 89% and 83%, chi-sq. = 6.1, 2df, p<.05), and people who were depressed were less likely than those with slight or no symptoms to say it was "enough" (67% vs. 89% and 85%, chi-sq. = 7.7, 2df, p<.05). It also varied by whether or not people said hearing was a problem that limited their activities (23% vs. 8%, chi-sq = 6.4, 1df, p<.05).

8.2.2 Whether People "Often" Felt Lonely

Respondents were asked if they "often" felt lonely during the past month. Thirty percent (66) said "yes." "Often" feeling lonely was related to many variables:

- Social Demographic Characteristics: Age (chi-sq=8.2, 2df, p<.05), sex (10.9, 1df, p<.001), marital status (chi-sq=16.5, 1df, p<.001), education (chi-sq = 7.1, 2df, p<.05), living group type (chi-sq = 24.1, 2df, p<.001), and type of residence (chi-sq = 11.7, 2df, p<.01) were related to loneliness. Those in the oldest age group, women, unmarried respondents, people with less education, those living alone, and senior housing residents were more likely than others to say they were "often" lonely.

- Health and Mental Health: Self-perceived health status (chi-sq = 12.0, 2df, p<.01), disability status (chi-sq = 12.0, 2df, p<.01) and depression (chi-sq = 41.0, 2df, p<.001) were related to "often" feeling lonely.[19] Those who felt their health status was fair or poor, who had a severe disability, and who were depressed were more likely than others to say they "often" felt lonely.

- Behavioral Measures of Social Connectedness: Geographic closeness of family (chi-sq = 5.3., 1df, p<.05), whether people still drive (chi-sq =19.0, 1df, p<.001), whether there was a relative who was a confidant (chi-sq = 4.8, 1df, p<.05), and whether people used a computer to keep in touch with family and friends (chi-sq. = 9.4, 1df, p<.01) were related to loneliness. People who did not have family members nearby, who did not have a family member who was a confidant, and who did not use computers to stay in touch with people were more likely to say they were "often" lonely.

- Feeling That Social Contact was Adequate: As might be expected, people who reported that their social contact with family members, friends, or neighbors was "not enough" were more apt to say they were "often" lonely (chi-sq = 7.0, 1df, p<.05).

[19] Loneliness was one of 8 items on the Depression Scale which was used in section 3, Mental Health. In order to use loneliness as a dependent variable in this section, we decreased the overlap by omitting loneliness from the Depression Scale for this analysis.

Table 8.1
Percent Saying They "Often" Felt Lonely
by Selected Characteristics (N=66)

Male	9	14%
Female	57	37%
Married	5	9%
Not married	61	37%
85 – 89	37	25%
90 – 94	20	39%
95 and over	9	53%
HS grad or less	25	39%
Some college or college grad	28	32%
Advanced degree	12	18%
Excellent/very good health	12	15%
Good health	22	30%
Fair/poor health	32	48%
No disability	23	20%
Frail	37	40%
Severe disability	6	50%
No depressive symptoms (excludes loneliness)	9	13%
Some symptoms (1-3 symptoms)	28	29%
Depressed (4-7 symptoms)	28	72%
Living with others	11	12%
Living alone	55	43%
Single family house	11	22%
Multiple family residence	21	22%
Senior housing	33	45%
Drives	13	14%
Does not drive	53	41%
Family is nearby	43	26%
Family is not nearby	23	43%
Relative is a confidant	47	26%
Relative is not a confidant	11	48%
Uses computer to keep in touch	13	17%
Does not use computer to keep in touch	53	37%
Social contact is enough	48	26%
Social contact is not enough	17	49%

8.3 Social Support Needs and Pressing Concerns

The survey asked respondents if they needed services or information. There were seven items about social needs. Thirty-one percent indicated they had social needs. The two most frequently mentioned were: information about social activities (such as Senior Center programs, volunteer activities, educational programs, or activities at places or worship) and information about activities to increase social contact with other people.

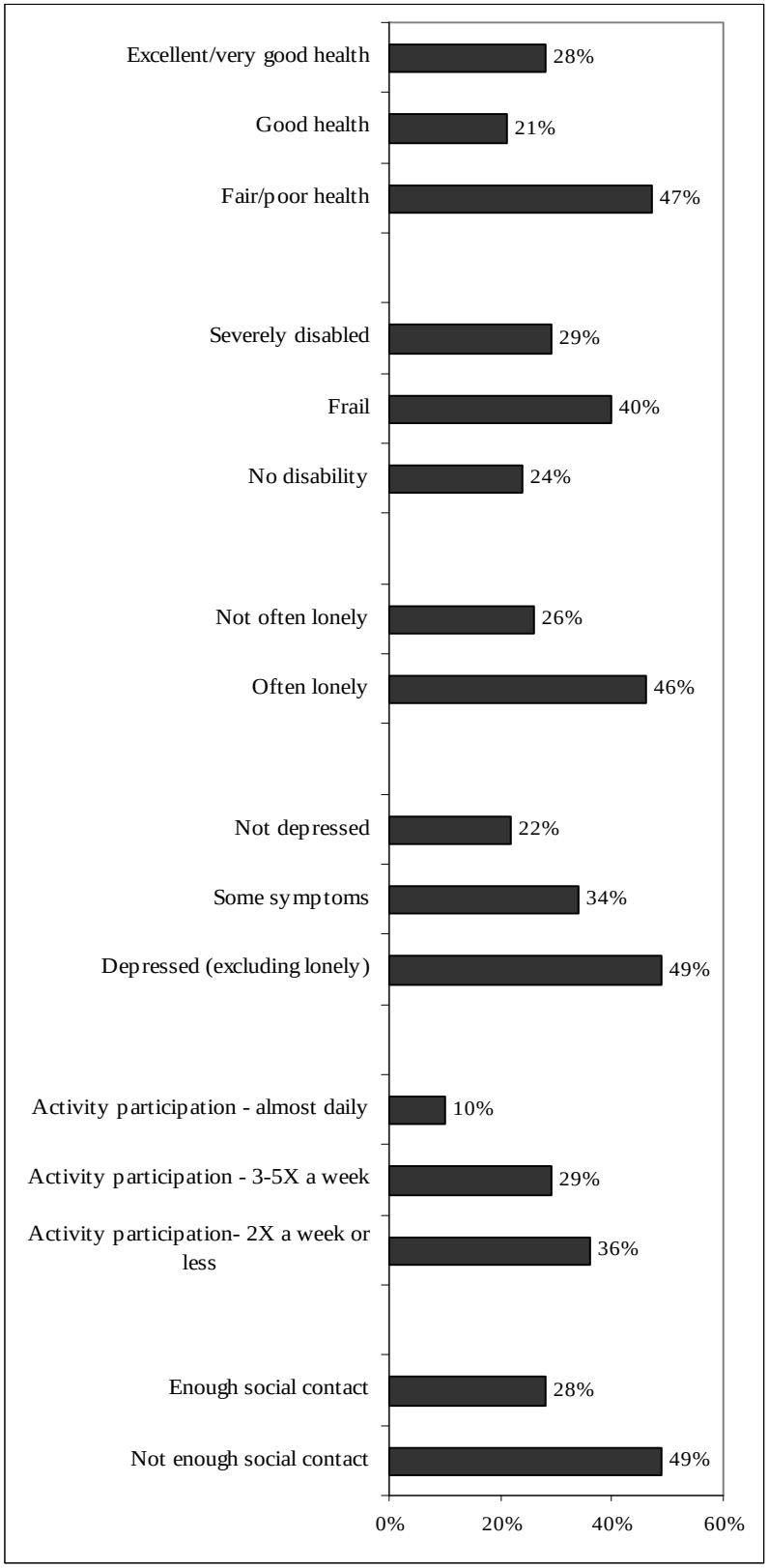
Table 8.2 Social Needs (N=223)

	N	%
Information about social activities such as Senior Center programs, volunteer activities, educational programs, or activities at places of worship	41	18%
Information about activities to increase contact	28	13%
Large print library books	19	9%
Friendly visitor, telephone assurance calls	14	6%
Talk about family problems	6	3%
Services for caregivers	3	1%
Assistance with pets	0	0
Total Number of Respondents with Social Needs	**70**	**31%**

Social needs were related to age (chi-sq = 9.2, 2df, $p<.01$); people in the two younger age groups were more likely to have social needs than those in the oldest age 95+ group (35% and 32% vs. 0%). Self-perceived health status (chi-sq = 12.0, 2df, $p<.01$), disability status (chi-sq = 6.3, 2df, $p<.05$), perceived loneliness (chi-sq = 8.1, 1df, $p<.01$), depression (chi-sq= 8.2, 2df, $p<.05$)[20], frequency of activity participation (chi-sq =7.1, 2df, $p<.05$), and whether one's social contact was "enough" (chi-sq = 5.8, 1df, $p<.05$) were related to social needs. Those whose health was "fair" or "poor," who were frail, who were "often" lonely, who were depressed, who had lower levels of activity participation, and who said social contact was "not enough" were more likely to have social needs.

[20] Here again, loneliness, one of the 8 items on the Depression Scale used in section 3 on Mental Health, was able to be used for this analysis because we decreased the overlap by omitting loneliness from the Depression Scale.

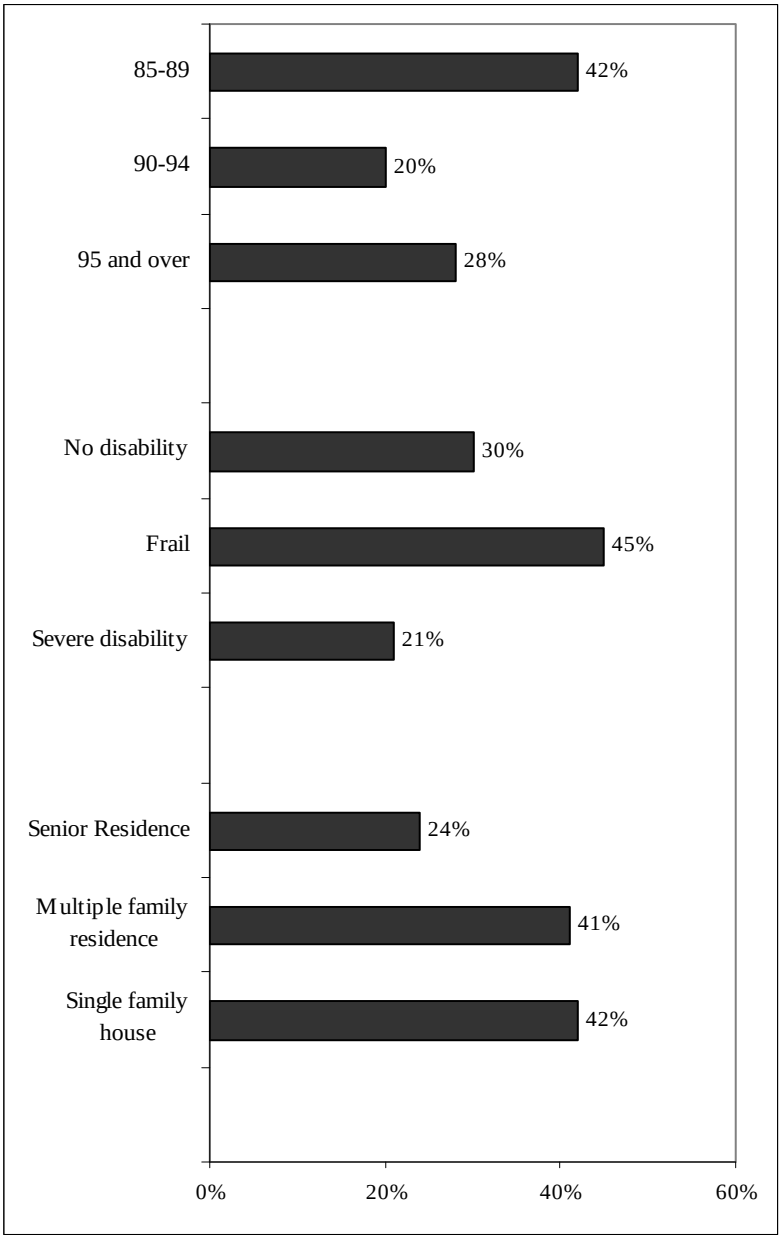
Figure 8.8
Percent Having Social Needs
by Selected Characteristics



8.4 Senior Center Newsletter

We asked respondents if they would like to receive the Brookline Council on Aging newsletter, if they were not receiving it already. Thirty-six percent (80 people) said "yes." The interest in receiving the newsletter was related to age (chi-sq = 8.9, 2df, p<.05), disability status (chi-sq = 5.9, 2df, p<.05), residence type (chi-sq = 6.8, 2df, p<.05).

Figure 8.9
Percent Wishing to Receive Senior Center Newsletter
by Selected Characteristics



When asked about their most pressing concerns, it was not surprising that many mentioned lack of companionship and/or lack of opportunities to engage with others in social activities:

Lack of companionship

"I have no friends to do things with. I don't have any activities that interest me."

"Loss of friends and family."

"Would like more friends since so many have died."

"I've lived here for more than 10 years but I have no friends. I want to go back to where I lived before."

"I'm lonesome."

"I have no family. The only relative is my nephew who lives far away. I have to call him. He doesn't call me."

"I don't feel like part of the community. I don't feel like reaching out now. It's too difficult."

"I'd like to get together with people my own age to discuss issues of aging.

Since my husband's death 5 years ago, I've missed the sharing of ideas (intellectual, personal)."

"I'd like to have a friendly male visitor visit and talk with me."(male respondent)

"I find it hard to be alone so much."

"I find it difficult to make new friends in Brookline. There are cliques here that are not interested in meeting new people. I miss my old friends."

"Loneliness"

More activities

"I miss theater and playing tennis."

"More opportunity to go out – attend plays, concerts. I take care of my disabled relative and don't have many opportunities to go out."

"Someone to walk with."

"There should be more activities".

Other

"I'd like to interact with younger people. I feel I have a lot of offer them."

"I'd like volunteers to read to me.

9.0 FINANCES

9.1 Perceptions of Financial Difficulties

The current economic downturn has put a financial strain on many households. Seniors living on fixed incomes tend to be particularly vulnerable and tend to be most affected by the increasing costs of health care. In addition, seniors have less time to recover from stock market losses they may experience.

To see how older Brookline residents were managing financially, respondents were asked, "At present, how well does the amount of money you have take care of your needs?" The response categories were: (1) "Are your expenses no problem for you?" (2) "Can you barely make your expenses?" (3) "Are your expenses so heavy that you cannot meet the payments?" Two hundred and seventeen people responded. Eighty-eight percent said their expenses were "no problem," while 12 percent (27) said they could "barely meet their expenses."[21] Respondents indicating problems meeting expenses were asked a structured question about the areas in which they were experiencing the greatest difficulties. The two areas which yielded the largest responses were health care/dental care/ health insurance and medications.

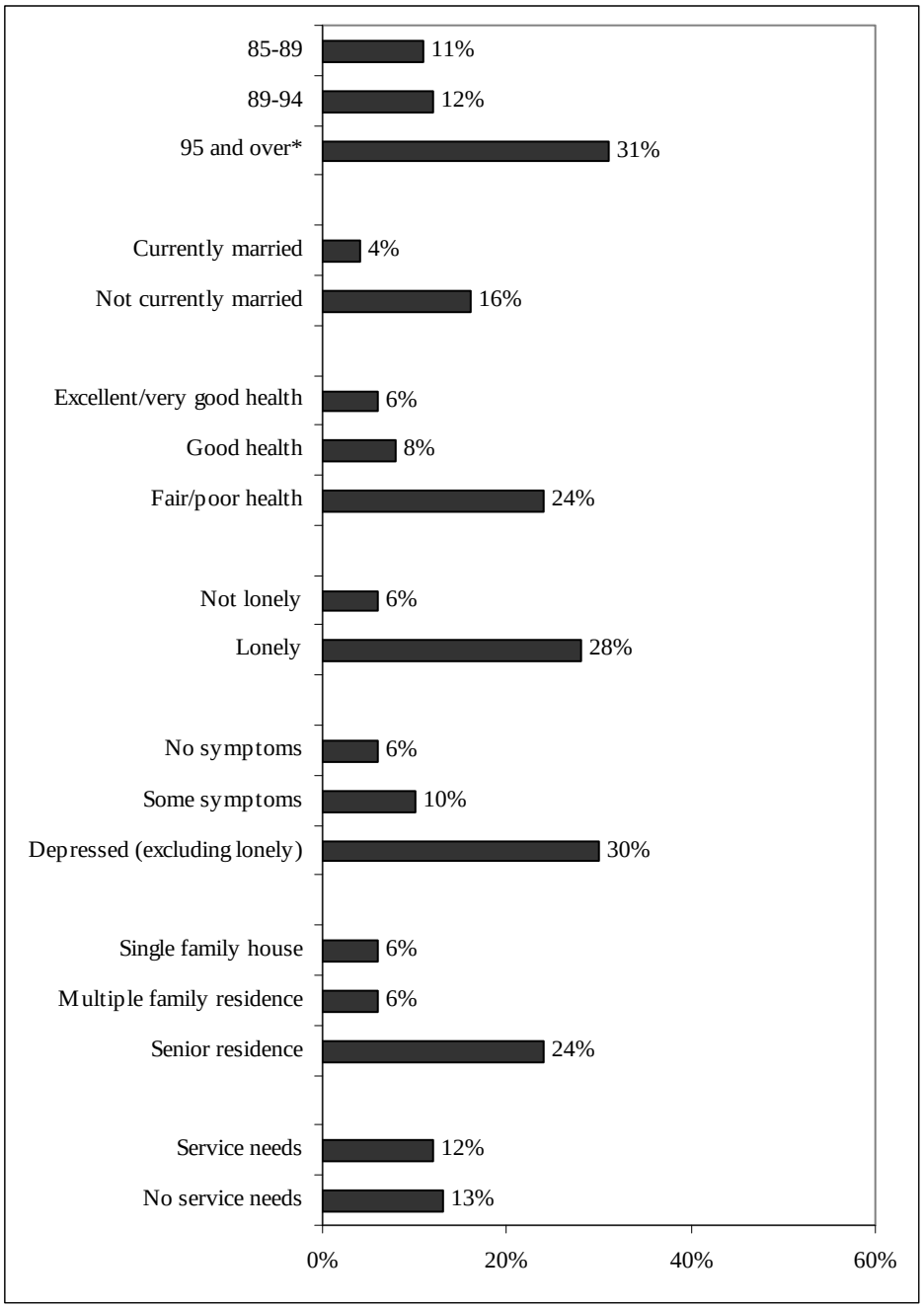
Table 9.1
Expenses Which Caused Financial Difficulties
(N=217)

	N	%
Health care, dental care, health insurance	7	3%
Medications	7	3%
Heat	6	2%
Home health aide	5	2%
Food	4	2%
Electricity	3	1%
Other areas (credit card debt, cable TV, telephone	3	1%
Property taxes	2	<1%
Payments for transportation	2	<1%
Income tax	2	<1%
Rent/mortgage	1	<1%
Car expenses	1	<1%
Total with Financial Difficulties	**27**	**12%**

[21] The 2000 Census reported that 12.8 percent of Brookline residents were below the poverty level. http://factfinder/census/gov. (August 17, 2010).

Having financial problems was significantly related to current marital status (chi-sq = 5.7, 1df, p<.05), self-perceived health status (chi-sq= 12,2, 2df, p<.01), loneliness (chi-sq=19.9, 1df, p<.001), depression – excluding loneliness (chi-sq= 13.5, 2df, p<.001), and residence type (chi-sq = 14.0, 2df, p<.01). Those who were unmarried, in fair or poor health, who "often" felt lonely, who were depressed, and who lived in a senior residence were more likely than others to experience financial difficulties. There was a slight tendency for respondents in the oldest age group to indicate problems; it was not statistically significant, but it approached significance (p<.10). There were no differences by sex, level of disability, and whether or not people had service needs.

Figure 9.1
Percent Experiencing Financial Difficulties
by Selected Characteristics (N=27)



9.2 Financial Needs and Pressing Concerns

Respondents were asked whether they needed some information or wished to speak to someone about financial or legal issues. There were five items in this area. Only 8 respondents expressed immediate financial/legal concerns.

Table 9.2 Financial/Legal Needs (N=223)

	N	%
Money management	1	<1%
Financial assistance	1	<1%
Other financial concerns	2	1%
Concern that someone is taking advantage of money	1	<1%
Speak to lawyer	7	3%
Total number of respondents with financial or legal needs	**8**	4%

Although few had difficulties meeting their expenses and/or had no immediate needs for information or services, when asked about their most pressing concerns, 19 percent (42 people) expressed concerns about their present financial circumstances and/or how they will be able to manage in the future. They were concerned about:

Their ability to pay for basic expenses: condo assessments, home repairs, property taxes, heating costs, personal home care, medical bills, ambulance bills, medications, personal home care, and food bills.

> *"There are costly condo repairs that are added onto my monthly condo fee and add to my everyday expenses."*
>
> *"I'm not getting as much (personal care) help as I need, and what I get isn't satisfactory."*
>
> *"Property taxes are a concern."*
>
> *"Having difficulty paying for food because I prefer macrobiotic food."*
>
> *"Trouble keeping up the house."*
>
> *"Very expensive to heat my house."*
>
> *"The cost of assistance and health care concerns me".*

"I'm concerned about a special assessment. The condo association has to upgrade the heat and ventilation system soon."

"I'm having a problem paying medical bills."

"Condo repairs add assessments on to everyday expenses."

"I'm having trouble paying medical bills"

"I'd like an emergency call system. It's very expensive. I'm waiting until I can afford one."

"The ambulance service continues billing me for deceased husband. My insurance should pay for this. I always depended on my husband to take of matters such as this."

Their ability to pay for anticipated future expenses.

"I'm worried about my husband's care. He has dementia, and his condition is worsening. How will I manage with very limited finances? Is a nursing home in his future? There's not enough money to cover present and future expenses related to my husband's needs."

"I live in an apartment on 3rd floor, and I have to walk up 3 flights of stairs. I should consider moving, but my finances are low and I'm afraid I can't afford anything else."

The need to cut down on expenses:

"I'm getting by, don't shop, minimal groceries."

"I should be making repairs, but will let them go."

"I meet my expenses, but I haven't gone on a vacation."

"I need to economize."

"I can no longer do what I thought I'd be doing due to the costs."

The need to receive financial help from children:

"My daughter gives me financial help when needed."

"I have little income. My daughter pays rent and utilities."

The future and outliving their finances:

"I hope my money to support my lifestyle doesn't run out."

"I can foresee future financial problems"

"I anticipate financial concerns down the road… that the money will run out before I die."

"I'm worried that I might, at some point, have financial problems.

"That money will last as long as I live"

"I'm worried I'll outlive my money."

"I worry about rising cost of living and outliving my means."

"Will my money last for my lifetime?"

"Even though expenses are no problem, I still worry about meeting expenses".

"O.k. financially, but I worry about it."

"I'm meeting my expenses, but I still worry about it."

"Trying to pay bills – remembering to pay them. I worry about money."

"I'm worried about the future….that money will run out."

<u>The need to see a financial planning counselor:</u>

"Would like to know of some trustworthy financial planning counselor I could talk to".

"I'd like to speak to a qualified person about my finances."

<u>The economy:</u>

"I'm worried about the state of the market".

"Instability of the economy."

"I hope the economy will improve."

"The economy."

"My family's and everyone's problems due to failing economy"

<u>Their children's financial circumstances:</u>

"I'm worried about my daughter who is not steadily employed."

"I'm concerned about the financial security of my son."

"My oldest daughter is in financial trouble."

10.0 A CLOSER LOOK AT SELECTED GROUPS

Thus far, this report has examined topics which are important for a study of the elderly – health, housing, transportation, social functioning, and finances. This section examines these same topics from a different vantage point by looking specifically at the groups we consider most vulnerable:

- people 95 years old and over (N=18)
- people who are severely disabled (N=14) or frail (N=93)
- people who are depressed (N=31)
- people with financial problems (N=27)

This section presents some new data and integrates results which were discussed earlier. The number of people in some of these vulnerable groups is small so caution must be exercised in interpreting this data. However, in spite of the small numbers, it is important to see if this type of analysis can yield information which can help in assessing unmet needs and service gaps.

10.1 Health

Access to Health Care

On the whole, these groups have been able to access medical professionals for check-ups, flu shots, and ophthalmology appointments. However, there were some differences when it came to dental visits. The higher the level of disability the less likely that people had dental check-ups during the past year. People with financial problems were also somewhat less likely to have had dental check-ups.

- 43 percent of the severely disabled had a dental check-up during the past year compared to 66 percent of the frail and 90 percent of the people with no disability, (chi-sq = 26.0, 2df, $p<.001$). In the sample as a whole, 77 percent saw a dentist during the past year.
- 62 percent of those with financial problems saw a dentist during the past year compared to 78 percent of those with no financial problems ($p<.10$). This result could be related to another pattern, namely that people with financial problems were more likely than others to say that tooth and mouth problems made it hard for them to eat (19% vs. 2%, Fisher's Exact Test, $p<.01$).

Need for Information and/or Assistance with Health Concerns

Eleven percent (25) had a need for information and/or assistance with health concerns. This was related to level of disability and presence of depression.

- Those who were severely disabled had more health service needs than those who were frail or who had no disability (21% vs. 16% and 6% (chi-sq = 6.6, 2df, $p<.05$).
- Those who were depressed had higher health service needs than those with some depressive or no depressive symptoms (23% vs. 11% and 5%, chi-sq = 2df, $p<.05$).

Need for Information and/or Assistance with ADL (Activities of Daily Living)
Eight percent (17) had a need for information and/or assistance with ADLs. Those who were frail and those who were depressed had a greater need for information and or help with ADLs than those who were severely disabled and those who had some or no depressive symptoms. As seen above, almost all of the severely disabled were receiving assistance with ADL.

- 14 percent of the frail compared with 7 percent of the severely disabled and 3 percent of those with no disability had ADL service needs (chi-sq = 9.3, 2df, p<.05).
- 19 percent of those who were depressed, 7 percent of those who had some depressive symptoms, and 2 percent of those with no depressive symptoms had ADL needs (chi-sq = 9.8, 2df, p<.01).

Assistance with Activities of Daily Living (ADL)
There was a strong relationship between disability and receipt of help: the higher the level of disability the more likely that people were receiving help.

- 93 percent of the severely disabled, and 77 percent of the frail were receiving help (chi-sq = 147.6, 2df, p<.001).

Nutrition and Medication Concerns
Thirty-seven percent had nutrition concerns. People who had financial problems and those who were either frail or severely disabled were more likely than others to have nutrition concerns.[22] Twenty-nine percent had medication concerns. People who were depressed were more likely than others to have medication concerns.

- 54 percent of those with financial problems and 33 percent of those without financial problems had nutrition concerns (Fisher's Exact Test, p<.05).
- 51 percent of the severely disabled, 51 percent of the frail, and 25 percent of those with no disability had nutrition concerns (chi-sq = 16.2, 2df, p<.001).
- People who were depressed were more likely than those who had slight or no depressive symptoms to worry about whether they were taking medications correctly (28% vs. 7% and 3%; chi-sq = 20.7, 2df, p<.001).

10.2 Mental Health

Depression
Fifteen percent were depressed. Age was not related to depression. However, people who were disabled (severely disabled or frail) and those with financial problems were more likely than others to be depressed.

- 20 percent of the severely disabled and 25 percent of the frail were depressed compared to 6 percent of those with no disability (Fisher's Exact Test = 26.7, p<.001).
- 36 percent of those who had financial problems were depressed compared to 11 percent of those who did not have financial problems (chi-sq = 11.5, 2df, p<.01).

[22] The survey asked five structured questions about nutrition: eating fewer than 2 meals a day, having tooth or mouth problems that made it hard to eat, losing weight without trying, eating poorly because of a decreased appetite, and gaining weight. These were summed and divided into two categories: nutrition concerns and no nutrition concerns.

\10.3 Housing

Home safety adaptations

Overall, 42 percent (93) of the respondents had emergency call systems. People who were 95 and older,[23] those who were severely disabled, those who were depressed, and those who had financial problems were more likely than others to have emergency call systems.

Table 10.1
Percent Who Had Emergency Call Systems by Selected Characteristics

	N	%
95 and over	14	82%
90-94	29	54%
85-89	50	33%
Chi-sq = 19.3, 2df, p<.001		
Severely disabled	12	86%
Frail	50	54%
Not disabled	31	27%
Chi-sq = 27.0, 2df, p<.001		
Depressed	21	68%
Some depressive symptoms	46	41%
No depressive symptoms	18	29%
Chi-sq = 13.2, 2df, p<.01		
Financial problems	21	81%
No financial problems	67	35%
Chi-sq = 19.6, 1df, p<.001		

The severely disabled and the 95 and over age group were more likely than others to have basic safety features (e.g., bathtub or shower grab bars, toilet grab bars, raised toilet seat, shower or tub seat, etc.) in their homes.

- 100 percent of the severely disabled, 87 percent of the frail, and 63 percent of those with no disabilities had basic safety features in their homes (chi-sq = 21.1, 2df, p<.001).

Those in the oldest age group were somewhat more likely to have more basic safety features than those in the two younger age groups:

- 94 percent of those 95 and over, 75 percent of those 90-94 and 73 percent of those 85 -89 had basic safety features in their residences (p<.10).

[23] 82% of the 95 and older group live in senior housing.

Need for Housing Information and/or Services
Twenty-eight percent (63) needed housing information and/or services. The 85-89 year old group was more likely to have a greater need than the older age groups for housing information and services.

- 36 percent of the 85-89 group, 13 percent of the 90 to 94 group, and 6% of those in the 95 and over group needed housing information and/or services (chi-sq = 2df, p<.001).

10.4 Transportation

Transportation problems
Fourteen percent (31) had transportation problems. Those who were severely disabled or frail, those who were depressed, and those with financial problems were less likely than others to drive. Therefore, it is not surprising that people in these groups were more likely than others to report transportation problems.

Table 10.2
Percent Who Had Transportation Problems by Selected Characteristics

	N	%
Severely disabled	3	23%
Frail	20	21%
Not disabled	8	7%
Chi-sq = 9.3, 2df, p<.01		
Depressed	10	32%
Some depressive symptoms	17	15%
No depressive symptoms	2	3%
Chi-sq = 14.6, 2df, p<.01		
Financial problems	7	26%
No financial problem	20	11%
Fisher's Exact Test, p<.01		

Need for Transportation Information and/or Services
Twenty-four percent (53) had a need for transportation information and/or services. The two younger age groups were somewhat more likely than the oldest group to need transportation information and/or services.

- 27 percent of those 85-89, 20 percent of those 90-94, and 6 percent of those 95 and over had transportation needs (p<.10).

10.5 Social Functioning

- There were no differences by age, disability, depression, or financial problems in regard to frequency of communication with relatives, friends, or neighbors.
- People who were severely disabled or frail had lower levels of activity participation outside their home than those who were not disabled (chi-sq = 16.8, 4df, p<.01); those who were depressed had lower levels of activity participation than those who were not depressed (chi-sq = 10.1, 4df, p<.05). There were no differences by age.
- People who were severely disabled were more likely than others to have check-up systems. 85 percent of the severely disabled, 60 percent of the frail, and 47 percent of those with no disability had check-up systems (chi-sq. = 9.0, 2df, p<.05). There were no differences by age.
- Sixteen percent (35) said social contact was "not enough." Those who were severely disabled, those who were depressed, and those with financial problems were more likely than others to say social contact was "not enough." Here again, there were no differences by age.

Table 10.3
Percent Who Said Social Contact Was "Not Enough" by Selected Characteristics

	N	%
Severely disabled	5	36%
Frail	10	11%
Not disabled	20	17%
Chi-sq = 6.1, 2df, p<.05		
Depressed	10	33%
Some depressive symptoms	17	15%
No depressive symptoms	7	11%
Chi-sq = 7.7, 2df, p<.05		
Financial problems	8	31%
No financial problems	25	13%
Fisher's Exact Test, p<.05		

- Thirty percent (66) said they were "often" lonely. People who were 95 years old or older and those who were severely disabled, who were depressed, or who had financial problems were more likely than others to say they were "often" lonely.

Table 10.4
Percent Saying They Were
"Often" Lonely by Selected Characteristics

	N	%
95 and over	9	53%
90-94	20	39%
85-89	37	25%
Chi-sq = 8.2, 2df, p<.05		
Severely disabled	6	50%
Frail	37	40%
Not disabled	23	20%
Chi-sq = 12.0, 2df, p<.05		
Depressed (excludes loneliness)	28	72%
Some depressive symptoms	28	29%
No depressive symptoms	9	13%
Chi-sq = 42.0, 2df, p<.001		
Financial problems	18	67%
No financial problems	46	25%
Chi-sq = 19.9, 1df, p<.001		

Information about Social Activities/ Social Support Services

Thirty-one percent (70) had social needs. People who were frail, who were depressed, and those in the two younger age groups were more likely than others to have social needs (need for information about social activities and activities that would increase their contact with others, friendly visitors, etc.). There were no differences depending upon whether or not one had financial problems.

Table 10.5
Percent Having Social Needs for
by Selected Characteristics *

	N	%
95 and over	0	0%
90-94	17	32%
85-89	53	35%
Chi-sq = 9.2, 2df, p<.01		
Severely disabled	4	29%
Frail	38	40%
Not disabled	28	20%
Chi-sq= 6.2, 2df, p<.05		
Depressed	17	55%
Some depressive symptoms	37	33%
No depressive symptoms	14	22%
Chi-sq = 10.0, 2df, p<.01		

* Excludes Senior Center Newsletter

10.6 Finances

Twelve percent (270 said they had financial problems. People who were depressed were more likely to say they had financial problems than those who were not depressed. There was also a slight pattern by age with people in the oldest age group more likely to indicate financial problems than others. There was no relationship by disability status.

- 31 percent of the depressed, 11 percent of those with some depressive symptoms, and 7 percent of those with no depressive symptoms had financial problems (chi-sq = 11.5, 2df p<.01).
- 31 percent of those 95 and over, 12 percent of those 90-94, and 11 percent of those 85-89 had financial problems (chi-sq = 5.6, 2df, p<.10).

10.7 Total Need for Services

All the individual service need items were aggregated (health, ADL, housing, transportation, social functioning, and finances) to see whether there were any differences in regard to the total need for information or services. In the sample as a whole, 63 percent (141) had a need for information and services and were referred to a Brookline Council on Aging (BCOA) social worker.

- People who had financial problems were no more likely to need information and/or services than people who did not have financial problems.
- People in the youngest of the 3 age groups (85-89 year olds) tended to have a greater need for services than those in the older age groups.
- Those who were frail or disabled tended to have higher needs for services than those who were not disabled.

- People who were depressed or who had some depressive symptoms were more likely to need information or services than those who were not depressed.

Table 10.6
Percent Indicating a Need for Information and/or Services by Selected Characteristics

	N	%
95 and over (n=8)	8	44%
90-94 (n=29)	29	54%
85-89 (n=104)	104	69%
Chi-sq = 6.9, 2df, p<.05		
Severely disabled	10	71%
Frail	66	70%
Not disabled	65	57%
Chi-sq= 4.6, 2df, p<.10		
Depressed	22	71%
Some depressive symptoms	78	68%
No depressive symptoms	49	49%
Chi-sq = 7.4, 2df, p<.05		

10.8 Some General Patterns Worth Noting

A number of different patterns are seen in relation to the topics we examined. However, four stand out:

- In regard to home safety, respondents in the four vulnerable groups were more likely to have emergency call systems than others, and the severely disabled were more likely to have basic home safety features and check-up systems than those who were frail or had no disability.

- Physical disability and depression were related to high levels of service needs. Those who were severely disabled or frail and those who were depressed or had some depressive symptoms were more likely to have a higher level of service needs than who were not disabled or not depressed.

- Respondents in the four vulnerable groups were more likely than others to express feelings of social isolation -- feeling that their social contact was “not enough” and/or that they were “often” lonely.

- Those in the youngest group (85-89) were more likely than those in the older groups (90-94, 95 and over) to have a greater need for information and services, especially for information and services related to housing and transportation.

11.0 RECOMMENDATIONS

This section presents recommendations based on the results of the survey and places these recommendations in context by summarizing the findings upon which they are based. These recommendations will be used as a blueprint for action that the Brookline Council on Aging (BCOA) can undertake in collaboration with other elder service providers to strengthen and expand services for Brookline's seniors.

11.1 INFORMATION ABOUT PROGRAMS AND SERVICES

Almost two-thirds of the respondents (63 percent) requested information and/or services. They were referred to social workers at the Brookline Council on Aging and were given a copy of the BCOA Elder Resource Guide, vol. 5, which contains detailed information about services and programs for Brookline seniors. Approximately one-quarter or more needed information and/or services in three areas: social activities and activities to increase contact with others, housing, and transportation. Fewer people indicated a need for information and/ or services in the areas of health, ADL (activities of daily living) or IADL (instrumental activities of daily living), and finances. Respondents who were severely disabled or frail and those who were depressed or had depressive symptoms were more likely to have a greater need for information and/or services than others.

Social Activities /Social Support	31 percent
Housing	28 percent
Transportation	24 percent
Health	11 percent
ADL or IADL	8 percent
Finances	4 percent

The fact that 63 percent needed information and/or services does not mean that these people were in a crisis situation and needed services immediately. A few had urgent needs, mainly for emotional issues, and they were promptly referred to BCOA social workers. Nor does it mean that Brookline is failing to provide the necessary support services to seniors who are living independently. It does mean, however, that accessibility to information is a problem area. In fact, there are so many access points to acquire information that it is quite overwhelming, and it can be difficult for people to know where to begin. Of course, it is also true that some people may not indicate a need for information or services because they may deny that they have problems or they may be unaware that there are resources which could be helpful. Thus, the number of people indicating a desire for information or services may actually understate the need.

Information about programs and services for Brookline's elderly is available from more than 10 separate sources: Springwell (designated by the state as the Aging Services Access Point [ASAP]); BCOA Elder Resource Guide, vol. 5; the BCOA Information and Referral Service; SHINE (a program that provides information about health insurance to seniors and disabled adults); Medicare; MassHealth; and Jewish Family and Children's Services. Also, the Brookline TAB newspaper publishes weekly information about activities and programs offered by the Brookline Council on Aging/Brookline Senior Center. Resource information is available from the Massachusetts Executive Office of Elder Affairs which has an Information and Resource

Unit (I & R); an interactive website www.800ageinfo.com; an electronic version of The Family Caregiver Handbook (assists family members in finding information and accessing services and gives advice about issues related to aging); and an online guide about planning for long-term care called Embrace Your Future. The BCOA also hosts a yearly program called the Newcomers Club which meets four times in the early fall and offers newcomers an opportunity to learn about Brookline -- the social, recreational, and cultural opportunities that are available to residents as well as the health and social service programs that offer services to seniors. Sometimes people who have lived in the area for a while also attend.

The survey findings indicate that many people are unaware of the programs and services that are available in the local community, and/or they may not know how to look for help, and/or where to start searching. This being said, many programs and services may not be fully utilized. Also people who see seniors on a regular basis, namely front-line professionals and employees, might be important referral agents; however, many may not be aware of services. Thus, a key problem is how to communicate this information in the most effective and efficient way both to seniors and to front-line professionals and employees (e.g., transportation providers and drivers; management and staff in multiple unit dwellings; members of the medical and allied medical professions; professionals or volunteers in religious, social, or community organizations; and employees in community businesses that serve many older adults).

Recommendations

11.1.1 Establish a relationship with and communicate with representatives from a broad array of governmental, community, health, business, and religious institutions to:

- *Share ideas about services that are currently available.*
- *Train people to recognize signs when older people need assistance.*
- *Learn about the services that they may provide to seniors.*
- *Discuss gaps in services.*
- *Discuss how best to tailor communications with the senior population since survey results indicated that people are unaware of the many services that are available.*

11.1.2 Based on the above, design effective communication strategies for different groups and different issues and determine senior preferences for:

- *The contexts (Doctor's offices, residences, libraries, Senior Center, religious institutions, etc.)*
- *The channels (interpersonal, small group, large group, etc.)*
- *The formats (newspaper, newsletters, flyers, cable, advertising, etc.)*

11.1.3 Consider ways to streamline information to make information more easily accessible.

11.1.4 Increase the number of free newsletters that BCOA sends to all Brookline adults who are 60 years old and older.

The BCOA publishes a monthly newsletter which costs $10 a year for subscribers. Currently, the BCOA mails one free issue (the September issue) to all Brookline adults who are 60 years old and over. BCOA should consider mailing two free newsletters each year to Brookline residents.

11.1.5 Develop an interactive website that centralizes information about programs and services for Brookline seniors.

At this point in time, approximately one-third of Brookline seniors 85 and older may be computer literate. This will certainly change in the near future as the oldest of the baby boomers are now retiring.

11.1.6 Consider recruiting and training BCOA information and referral specialists for outreach, such as:

- *Drop-in hours at senior residences, the libraries, as well as the Brookline Senior Center so people can meet with information and referral specialists to inquire about needed programs and services*

- *Visits to the homes of newcomers to see how they are adapting to their new living situations and to see if they need individualized information about programs and services*

- *Telephone calls on a semi-regular basis to help connect people to resources since survey results showed that people do not know what is available*

- *Follow-up calls to ensure that seniors received the information they needed and were able to access services*

At present, trained volunteers as well as staff and social work interns handle calls coming in to the Information and Referral Service at the BCOA. There has been little opportunity, thus far, for outreach.

11.1.7 Consider writing a series of articles that address different topics and which can be targeted to different types of audiences:

- *A question and answer article in the Brookline Tab called "Ask the Senior Center" could not only tackle important and commonly-asked about issues, but it could also publicize the availability of the BCOA Information and Referral Service.*

- *Articles in church and temple bulletins or organizational newsletters (e.g., Rotary, Chamber of Commerce, etc.) could publicize programs and new initiatives.*

11.2 SOCIAL CONNECTIONS/ SOCIAL ENGAGEMENT

In many ways, the majority of respondents seemed well-connected socially (almost two-thirds communicated with family, friends, or neighbors almost every day, and 89 percent had a relative who was a confidant). However, almost one-third (30 percent) "often" felt lonely, and 31 percent said they would like information about social activities to provide intellectual stimulation and increase their social contact. In fact, among all the topics surveyed, social needs ranked the highest. In addition, when asked about their most pressing concerns, many mentioned lack of companionship.

Loneliness can occur at any age, but it is more likely to occur among the elderly as significant others have died, children have grown and moved out, occupational and social networks have weakened after retirement, mobility issues have arisen, and driving abilities have changed. The question is: What can be done to provide opportunities for engagement not only to somewhat assuage loneliness but also to permit people to strengthen their social networks and provide them with opportunities to develop meaningful relationships and feel valued and integrated into the community?

Recommendations

Many of the following recommendations are discussed more fully in other sections so they are only briefly mentioned here.

11.2.1 Develop neighborhood support systems through neighborhood associations and/ or the new electronic technology that can streamline the process.

A recent New York Times article, July 29, 2010, entitled "Technology for Monitoring Elderly Relatives" by Eric A. Taub mentioned a new website called Lotsa Helping Hands (lotsahelpinghands.com). People who participate in this communication network receive regular email alerts which are posted on an electronic calendar; individuals who read the alerts can volunteer. There can be reciprocity between seniors and younger people; seniors can help younger people and younger people can help seniors. Of course, seniors need to have computers and be comfortable going online to request assistance. Although one wonders about security and privacy issues, still, this is an interesting option. Lotsa Helping Hands is in the process of being piloted locally by Temple Israel in Boston.

11.2.2 Encourage senior volunteerism. (*Discussed in section 11.3.)*

Working with others on a shared activity which has social value is an excellent way to develop personal relationships. It can contribute to a sense of self-worth and a feeling of being part of something larger than oneself.

11.2.3 Investigate other intellectual offerings that might engage seniors who prefer more in-depth or challenging intellectual programs and continue to publicize existing options. (Discussed in section 11.4).

11.2.5 Develop a network of buddy systems for different activities: walking or exercise buddies, check-in buddies, book buddies, driving buddies, etc). (Discussed in sections 11.3, 11.6. 11.8.)

11.2.6 Publicize the availability of respite programs so caretakers can participate in fulfilling activities outside their homes. (Discussed in section 11.7.)

11.2.7 Encourage seniors with certain impairments (hearing, depression, etc.) to participate in self-help groups. (Discussed in sections 11.14 and 11.15.)

11.2.8 Continue to encourage and support the creation of peer-led groups. For example, some seniors initiated the formation of a Senior Center Theater Club: seniors attend low-cost, local theatrical productions and are provided with transportation.

11.3 SENIOR VOLUNTEERISM/ COMMUNITY ENGAGEMENT

Seventeen percent of respondents participated in formal volunteer activities for an organization. This was a larger percentage than had been anticipated, and it probably underestimates the amount of volunteering that goes on since a number of people do informal volunteering (e.g., reading to a blind neighbor or spending time with a friend who was diagnosed with Alzheimer's).

Thirty percent of the respondents said they "often" felt lonely. Volunteering might help combat feelings of loneliness since working together with others toward a shared purpose is a good way to form meaningful social relationships. Moreover, Brookline seniors tend to be well-educated, and they might welcome the chance to use their skills and contribute to the community.

The Brookline Senior Center has a large pool of volunteers who assist with programs and activities. The Brookline Tab publishes weekly volunteer notices. The Department of Public Health has a volunteer program called the Medical Reserve Corps (MRC), and the Police Department has a volunteer program called Community Emergency Response Teams (CERT). The Brookline Community Foundation has a website that lists volunteer activities called "yourbrookline.org" and, in connection with the celebration of Brookline's 300th anniversary, the Brookline Community Foundation published a booklet called "Brookline Gives" that lists local organizations that make use of volunteers.

Although some volunteer activities might be familiar to people, there may be Brookline organizations (town departments, community service organizations, non-profit organizations, schools, day care centers) that have volunteer opportunities which are not well known. More seniors might volunteer if they were aware of the available opportunities; if the list of volunteer activities and assignments was centralized in a hard-copy publication and/or a website; and if there were volunteer coordinators who might help them find suitable activities. In addition, there may be a number of Brookline organizations that could benefit from the participation of seniors as volunteers but are unaware of the value these volunteers could bring to their organization.

<u>Recommendations</u>

11.3.1 Update the list of Brookline volunteer opportunities which were published in 2007 in "Brookline Gives.

11.3.2 Collaborate with the Brookline Community Foundation which has the <yourbrookline.org> website as well as with the Norfolk County RSVP (Retired Senior Volunteers Program), a nationwide volunteer program for people 55 and over.

11.3.3 Encourage and expand inter-generational volunteer activities, partnering with Brookline Schools. One survey respondent commented, *"I'd like to interact with younger people. I feel I have a lot to offer them."*

11.3.4 Integrate the volunteer opportunities onto an electronic database that is easily accessible to provide one-stop shopping and provide a hard-copy version also.

11.3.5 Have a Volunteer Fair where prospective volunteers can talk with representatives of organizations and groups that need volunteers.

11.3.6 Consider creating a position called Volunteer Coordinators (either paid or volunteer) to help match individuals to volunteer opportunities.

11.3.6 Develop a neighbor-to-neighbor volunteer program within neighborhoods. Match people on the basis of individual needs and interests. (Also discussed in 11.2.1)

For example, seniors might be available to babysit, watch people's homes while they are away on vacation and water their plants, amuse or read books to children while parents are home doing other work. Younger adults might help seniors with shopping, gardening, changing a light bulb, trouble-shooting computer problems, etc..

11.3.7 Continue to recruit, train, and support volunteers for BCOA programs.

11.4 SOCIAL AND INTELLECTUAL ACTIVITIES

When asked, "Are there some services or activities that are not currently available to Brookline residents that you think should be offered?" some people mentioned they would like more intellectually stimulating activities to be offered to seniors. They commented:

> *"More activities for higher functioning elders."*
>
> *"It would be better if suitable programs at the Senior Center could be offered for more than just one hour, perhaps half a day."*
>
> *"Activities with a higher educational level"*
>
> *"Want the Senior Center to hold more political/current events classes."*

Recommendations

11.4.1 Hold focus groups with seniors to see what types of programs they prefer.

In the past, the BCOA has mailed surveys to seniors to ask about preferred activities. Perhaps some focus groups would provide another type of information since ideas are often generated when people get together that might not be generated by filling out a questionnaire at home.

11.4.2 Investigate the types of activities offered by Brookline Adult and Community Education (BACE) that seniors frequent and see if some can be held during the day.

The survey did not provide information about the types of activities that might be desired. However, one respondent indicated that BACE offers too many classes at night. Therefore, a starting point might be to see whether some adult education classes that are frequented by Brookline seniors might be held during the day. If BACE has statistics about the age distribution of people taking adult education classes, this data might help to determine the types of classes

that would be of interest to an older population and perhaps some could be offered during the day.

11.4.3 Consider exploring other venues (e.g., community rooms in churches and synagogues, apartments/condos, and town departments) for senior activities for people who are not interested in attending a traditional senior center and for people who do not live near the Coolidge Corner/Senior Center area. For example, South Brookline might be a good location to hold programs.

11.4.5 Promote other educational and cultural opportunities:

- *BCOA could partner with the Boston University Evergreen Program or the Osher Programs which are offered at Tufts, University of Massachusetts, and Brandeis.*

- *Consider creating one-day learning adventure programs that would explore the many educational and cultural assets of the metropolitan Boston area. This could be modeled after the Elderhostel Program.*

11.5 COMPUTER USAGE

Thirty-five percent of the respondents had a computer which they used to keep in touch with family and friends. People who used computers were more likely to be males, to be better educated, and to be in better physical and mental health than those who did not use computers. It is predicted that computer usage will become more prevalent over time as more of the baby boomer generation move into their senior years. When this generation comes of age, it is probable that sex, education, and health will no longer be factors influencing computer usage and that the vast majority of seniors will use computers.

Computer literacy can help enhance social engagement and reduce social isolation since people can use email or Facebook to communicate with relatives and friends and use Skype or similar programs to make video calls. Computer usage presents individuals with the opportunity to order groceries, medications, clothing, books, and gifts online. People can also pay bills, conduct banking transactions, sign up for online interactive classes, participate in Webinars, and watch movies, etc.. All these activities are particularly helpful for seniors whose ability to engage in social activities outside the home may be limited because of health, mobility issues, and access to transportation.

In their study of *Chronic Disease and the Internet*, the Pew Research Center found that people with chronic diseases are less likely to have internet access, but those who do are able to access information that helps them with personal issues as well as health problems (http://pewinternet.org/Reports/2010/Chrinic-Disease.aspx).

Lack of technological expertise as well as cost is barriers to the use of computers among the elderly. Aside from the expense of purchasing a computer, experts must be called upon to set up the computer and troubleshoot problems; home-based computer experts have high fees.

The BCOA offers special computer programs for seniors, and there are people on hand at the Computer Lab during non-class times to answer questions. Brookline Adult and Community Education also offers many computer classes.

Recommendations

11.5.1 Encourage computer usage among seniors by holding educational programs to address the benefits of computer usage as well as Computer Fairs where seniors are invited to test out various computers.

11.5.2 Continue to publicize and promote special computer classes for seniors.

11.5.3 Encourage people to stop by the Senior Center and visit the Computer Lab to try out various programs.

11.5.4 Offer individualized computer training at the Computer Lab for people who do not want to sign up for a series of classes, but only want limited assistance with a specific program.

11.5.5 Enlist the aid of high school students or other community residents as volunteers who can offer individualized home-based assistance (e.g., help set up computers, teach fundamentals, and trouble-shoot problems, etc.).

11.5.6 Although computer literacy for most seniors is the goal, we need to be sensitive to the fact that many of today's elders are not comfortable with technology and, therefore, we need to provide special outreach to this group by mail and/or telephone calls to keep them involved in community activities.

11.6 CHECK-UP SYSTEMS

Fifty-four percent of the respondents had a formal or informal check-up system whereby someone checks up on them or they check up on someone else on a regular basis. People who were disabled, who communicated with relatives/friends/neighbors 3 times a week or more, or who had relatives as confidants (people they could talk to about important problems or decisions) were more likely than others to have a check-up system. People living alone were no more likely than others to have a check-up system.

Recommendations

11.6.1 Health and social service professionals should encourage seniors to have a formal or informal telephone check-up system.
In particular, this should be encouraged for those who live alone and for those who are not in close, regular contact with people.

11.6.2 Explore the possibility of helping people set up their own peer-to-peer buddy system.

The Brookline Senior Center could provide people with the opportunity to be matched up with others based on similar characteristics, such as age, sex, geographic area, interests, etc.

11.6.3 Provide educational programs about existing computerized check-up systems and keep people informed about the new technologies as they arise.

11.6.4 Publicize the Telephone Reassurance Program (R.U.OK), a free computerized telephone reassurance service that is run out of the Norfolk County Sheriff's Department.

The questionnaire did not ask respondents about the Telephone Reassurance Program so we do not know how many respondents are registered for this program.

A newer R.U.OK system called CARE (www.callingcare.com) is now available which uses technical products that can detect differences between an answering machine and a line-answered call. Thus, CARE members do not have to turn off their answering machines if they subscribe to this service. People can sign up by calling the BCOA.

11.7 CARETAKING

Nineteen respondents were caring for people who were unable to care for themselves. Twelve were caring for someone in their own home, and among this group, 10 were caring for a spouse. Although not statistically significant, less than half of the caretakers participated in activities outside their home more than once a week. In contrast, more than two-thirds who were not caretakers participated in activities outside their home more than once a week. Only 3 caretakers were interested in talking with someone about services that are available to help people who are caring for others. There seem to be two issues:

- Caretakers may be reluctant to ask for help for themselves. They think they should be able to do it all. For example, an interviewer commented:

  "Respondent is the caretaker for her husband who is in the final stages of inoperable cancer and has dementia. She receives help from a home health aide and from hospice. Although she is often overwhelmed with his care, she is ambivalent about expressing a need for help for herself. She was finally able to say it would be wonderful if someone could help her with yard work."

- Caretakers may lack knowledge about the resources that are available. Another quote from an interviewer:

  "Respondent's wife has Alzheimer's and requires full-time care and supervision. He could use respite time for himself. He wondered whether there were volunteer caretakers available for a few hours a week."

<u>Recommendations</u>

11.7.1 Information about services for caregivers needs wider distribution.

The BCOA Elder Resource Guide, vol. 5, has information about organizations that provide respite services both in the home and in an outside facility.

11.7.2 Publicize and promote awareness of the services BCOA can provide to caregivers.

BCOA administers a program called H.E.L.P. (Home and Escort Linkage Program) which can provide caretakers with respite care. To combat the reluctance of caregivers to utilize outside help, the BCOA currently has a special grant-funded program that provides 12 hours of free respite care. This offers caregivers the opportunity to test this service and see if they are comfortable using it.

11.7.3. Advocate and solicit grantors for continued funding of the above respite program that BCOA administers.

11.7.3 Educate and sensitize the caregiver's health network about the availability of and importance of respite and support group services for caregivers.

Caregivers and their loved ones are tied into a health care network composed of physicians and, in some cases, home health aides and hospice workers. These professionals need to educate caregivers about the importance of caring for themselves and avoiding burnout by socializing, exercising, and engaging in activities that are rewarding.

11.7.4 Publicize and promote awareness of support groups in the community for caregivers. (Examples: There are caregiver support groups in the community for Alzheimer's disease, dementia, and Parkinson's disease, etc.).

11.8 TRANSPORTATION

Transportation was one of the three areas where people had the greatest need for information. This is not surprising since there are many different types of transportation services that are available, aside from the regular MBTA (which is best suited for those who have no or minimal disabilities) and regular taxis. These different options include: Brookline Senior Center Van, Brookline Elder Taxi System (BETS), the MBTA Ride, Springwell's Busy Bee transport, and Partners Health Care shuttles. There are also a small number of medical escort options (H.E.L.P – sponsored by BCOA; Friendship Works -- formerly Match-up Interfaith Volunteers; and Springwell); and some private van options. It is a complicated system and people may not know what is available or even how to begin searching. Each service has different financial eligibility requirements. There are specific times of the day when appointments must be made. Some of these services are "fixed" route services; few are demand-responsive providing personalized service; and, for most of these options, people need to schedule rides one or two days in advance.

Forty-two percent were still driving and many had imposed restrictions on their own driving because they were not comfortable driving at night, in bad weather, or for long distances; 58 percent were not driving.

Survey data indicated that communication with relatives, friends, and neighbors was much more frequent than activity participation. Judging how complicated the transportation system is and how few opportunities there are for transportation to friends homes or restaurants or other places which are not accessible by public transportation and not on established routes, it is easy to understand the reasons for this discrepancy.

Recommendations

11.8.1 Provide centralized electronic information about the different transportation services.

11.8.2 Have one brochure that clearly describes all the transportation options in chart form.

11.8.3 Publicize some of the available options more widely.

For example, 22 percent of the survey respondents were not familiar with the BCOA H.E.L.P Program (Brookline's Home and Escort Linkage Program) which, for an affordable rate, can provide escort service. Fifteen percent were unfamiliar with Springwell's Busy Bee transportation option which offers transportation to medical appointments. Also, people were unaware of BCOA's Library Connection Program which provides volunteers who deliver and return library books for people whose disability makes it difficult for them to leave their home.

11.8.4 Consider holding a public information session about driving alternatives.

Making the transition from driving to non-driving is a very emotional decision. It is made even worse when one does not know about possible transportation alternatives.

11.8.5 Enlist the aid of volunteers to help elders apply for services as well as to help them fill out the forms.

11.8.6 Explore the possibility of having neighborhood driving buddies.

Some people who still drive might volunteer to be a driving buddy for others in their neighborhood who no longer drive. Neighborhood meetings might provide the opportunity for people to make these types of connections and/or people could register for this program through the BCOA.

11.8.7 Explore new low-cost transportation programs.

Consider having an agency such as BCOA or a transportation service sponsor TRIP (Transportation Reimbursement and Information Program), a new model for providing individualized transportation at a low cost to older adults who no longer drive. People who sign up for TRIP recruit their own drivers (e.g., relatives, friends or neighbors). Through mutual agreement, rides are arranged between passengers and their drivers. Reimbursement for mileage is given to the riders who then give it to their drivers.
The sponsoring program must purchase special software to manage and administer the service as well as hire a manager. (<www.healthmattersinsf.org>)

11.8.8 Keep informed of new technology that offers the opportunity for demand-responsive transportation.

Given the advanced technology that is now available for scheduling and that will be more widely available as time goes on, transportation companies may someday be able to offer same-day scheduling.

11.8.9 Provide counseling and educational forums for elders and their family members which can help people make informed decisions about when to stop driving..

11.9 SUPPORT FOR THOSE WISHING TO CONTINUE TO LIVING INDEPENDENTLY

Our survey did not ask those who were considering a move whether a move was something they really desired rather than something that was necessary because the demands of their living environment (housekeeping, home repairs, home maintenance, and yard work) were becoming overly burdensome. A number of respondents, whether or not they were considering a move, mentioned having problems with home repairs, yard work, and snow shoveling.

Recommendations:

11.9.1 The Brookline Council on Aging's Elder Resource Guide, vol. 5, lists some home repair/handyman services. The BCOA should continue to update this list.

11.9.2 The development of a neighbor-to-neighbor mutual aid system (discussed elsewhere) might be very helpful.

11.10 HOUSING ALTERNATIVES: A SINGLE FAMILY HOME, A CONDO, AN APARTMENT, OR A SENIOR LIVING COMMUNITY

Forty-five percent of the respondents were home owners; 22 percent lived in single-family homes. When asked whether they needed information or services, 13 percent indicated an interest in housing alternatives (assisted living, senior housing, etc.), and 12 percent mentioned they were thinking about moving from their current residence. Approximately one-quarter (26 percent) of those living in single family residences were considering moving compared to 13 percent in multiple family residences, and 4 percent in senior residences. If people wish to continue to live independently in their own communities, and reports say that most do, many are unaware of the available options as well as the pros and cons of each of these options.

Recommendations:

11.10.1 Continue to offer educational forums which discuss the various options available, such as moving from a single family home to an apartment, a condo, or a senior living community.

11.10.2 Continue to offer individual counseling for those having difficulties weighing the various options.

11.11 HOUSING ALTERNATIVES: ACCESSORY DWELLING UNITS

Since many people generally wish to stay in their own homes or, at least, in their own community, there is a need for a wide a variety of living options. Brookline has single family homes, condos and apartments, apartments designated for the elderly, assisted living residences, and nursing homes, but Brookline does not have accessory dwelling units, a residential option that other communities have adopted quite successfully and that AARP recommends.

An accessory dwelling unit is a separate unit inside a single family house that has a separate entrance, bathroom, and cooking facilities. Older adults might live in an accessory dwelling unit in a child's home. Also, a full or part-time caretaker might live in a unit in the home of an older adult who is capable of self-care but requires some assistance. This person could help with daily activities, home maintenance, and provide companionship.

Recommendation

11.11.1 Encourage Brookline's Town Meeting to explore the issue of accessory dwelling units again.

An accessory dwelling unit warrant article was brought before the Brookline Town Meeting in May 2009. Although the article placed restrictions on the types of homes which might be eligible, and, thus, limited the number of homes that might fall into this category, the article failed to pass. The issue is complex and cannot be discussed here in depth, but this type of living option should be considered for the future and should be revisited by Town Meeting.

11.12 HOUSING ALTERNATIVES: INFORMATION ABOUT PUBLIC HOUSING AVAILABILITY

11.12.1 Consider ways to increase awareness in the community about the availability of apartments in Brookline's senior housing developments.

The open-ended comments revealed that a number of residents were concerned about outliving their finances. It is likely that there may be resources available about which residents are unaware. For example, in regard to housing, there are approximately 450 senior public housing units. Brookline residents get preference and there is a relatively short waiting period after filing an application for an apartment (presently 6 months or less).

11.13 FALLS

Thirty-five percent of the respondents reported that they had fallen during the past year and half of them were injured. Among this group, 49 percent fell inside their home; 42 percent fell outside; and 9 percent fell in both places. Falls were related to disability status with more falls occurring among the severely disabled and the frail than among those with no disabilities. As people aged, the location of falls occurred more commonly inside the home.

Sixty-six percent of those who had fallen used walking aids, and 33 percent did not. We do not know whether people started using a walking aid after a fall or whether they were using a walking aid at the time of the fall.

There are many reasons why people fall. They include:

- Incorrect use of assistive devices
- Medical conditions (arthritis, foot problems)
- Impaired vision or improperly fitted eyeglasses
- Improper clothing or shoes
- Poor lighting (inside and/or outside the home)

- Side effects of medication
- Difficulties with balance
- Environmental issues inside the home (stairs, scatter rugs, improperly placed furniture, extension cords, etc.)
- Environmental issues outside the home (stairs, snow or ice, uneven sidewalks, etc.)
- Walking in an unfamiliar environment

Recommendations

The following recommendations address a few of the above conditions that may lead to falls:

11.13.1 Encourage people to visit podiatrists to assess shoe suitability.

Many seniors may be wearing improperly fitted shoes or shoes that do not offer enough support. People should be encouraged to visit podiatrists so podiatrists can assess the suitability of the shoes they are wearing and determine whether orthotics might be needed. (Note: Medicare covers the cost of podiatry services and special shoes for people who are diabetics.)

11.13.2 Assess environmental issues in the home and suggest modifications and safety features.

- Retired health professionals, such as physical therapists, occupational therapists, and nurses, might volunteer to come to a person's home to conduct safety checks.

- Physical therapists, occupational therapists, or nurses could train volunteers to go into homes to conduct safety checks. Brookline has a Medical Reserve Corp (MRC) and a Community Emergency Response Team (CERT). Brookline might start a Safety Corps of volunteers, modeled after the above volunteer groups, who would conduct home safety checks.

- Jewish Family and Children's Services Aging at Home Grant included a pilot program to assess home safety issues which could be replicated town-wide.

11.13.3 Provide information that can assist elders who wish to adapt their living space to meet their current and future needs.

- Develop a clearinghouse of information about universal design and home modifications.

- Develop a database of qualified contractors who know how to adapt living spaces to meet the needs of people who have disabilities or physical limitations.

- Offer educational forums which provide information about:
  --hiring a contractor and writing a contract
  --low-interest or no-interest loans that are available for home modification.

11.13.4 Work with the Brookline Police and Fire Departments to develop a protocol for notifying the BCOA if they have been called to an elder's home <u>more than once</u> during the year because of a fall.

Currently, BCOA is notified if firefighters or police officers think there is a problem.

11.13.5 Seniors need to be informed about and encouraged to use a "fall alert" personal emergency call system which alerts a service if a person has fallen. (See discussion below about emergency response systems).

11.14 PERSONAL EMERGENCY RESPONSE SYSTEMS

Forty-two percent of the respondents had personal emergency response systems. Those who are considered most vulnerable (people 95+, the severely disabled, and those living alone) were more likely than others to have these systems. Still, 58 percent of those 85 and over did not have a personal emergency response system, and 9 percent indicated they wanted information about this.

Emergency response systems often have two components – an activator (either a necklace pendant or a wristband) and a communicator or console (a speaker connected to a telephone). If a person becomes ill or has an accident in their home, s/he can press a button on the activator which sends a signal to the communicator. There are also special "fall alert" necklace pendants that can detect if a person has fallen and place an automatic call for help if a fall is detected and the person is unable to push the button. In addition, there are passive monitoring systems (motion detectors) that can detect falls as well as unusual movement patterns or lack of motion. The latter system can alert neighbors, family members, and, as a last resort, call 911 if the person cannot be reached by telephone.

These monitoring systems improve safety, increase independence, and prolong aging in place. However, it might not always be easy to convince an older person to invest in this type of system due to: cost, denial that there is a need, distrust of technology, the fear of false alarms, the risk of equipment failure, and the fear of the invasion of privacy.

<u>Recommendations</u>

11.14.1 Publicize more widely that Springwell has personal emergency response systems for income eligible seniors.

11.14.2 Health and social service professionals who provide services to seniors should encourage seniors to have personal emergency response systems in their homes.

11.14.3 Educational programs should be held to: (1) educate people about the benefits of personal emergency response systems, (2) alleviate concerns they may have about these systems, and (3) present information about the various types of systems that are available.

11.14.4 Technology in this field is always changing. The BCOA can take a leadership role in being aware of and publicizing new technologies.

A number of companies offer remote monitoring systems, and the BCOA Elder Resource Guide, vol. 5, has a list of companies that carry these systems. This information can be updated on a regular basis and published in the BCOA newsletters. Also, the BCOA Information and Referral Service can provide updated information.

11.15 PHYSICAL EXERCISE

Fifty-eight percent said they engaged in physical activity such as walking, yoga, or gardening for at least half an hour three times a week or more. The survey question was not specific enough to give us the information needed to assess the adequacy of the activity in which people were engaged. However, our data indicated that those who engaged in physical activity were less likely to have fallen during the year. Thus, exercise needs to be encouraged for all. The 2008 national physical guidelines of the Department of Health and Human Services mention the importance not only of strength training and aerobic exercise, but also the importance of balance exercises. Their research shows that falls can be reduced by participating in regular physical exercise programs that include balance exercise in addition to muscle strengthening and aerobic conditioning (www.health.gov/paguidelines/guidelines/chapter5.aspx).

Many seniors are reluctant to join a health club thinking that health clubs are only for younger, more physically fit people, and they may be embarrassed by the level of their physical conditioning. Also, the cost of some exercise programs may be prohibitive.

Recommendations

11.15.1 Publicize more widely the availability of home-based exercise offered by FriendshipWorks.

For people not comfortable attending a class or whose health or disability prevents them from attending a class outside their home, FriendshipWorks (formerly called Match-up Interfaith Volunteers) has a Strong for Life Program where a trained volunteer comes to a person's home to assist him/her with exercises designed to improve strength and balance. We need to see how well-utilized the program is by Brookline residents and how we might better publicize it so that more people can take advantage of this opportunity.

11.15.2 Explore the creation of other low-cost home-based and residence-based exercise programs (e.g.. some could, take place in the community room of a multiple unit residence).

11.15.3 Publicize more widely the availability of exercise classes in the local community that cater to older adults. Fees for these programs vary.

These include:

- Brookline Adult and Community Education (BACE) offers exercise classes for older adults, and a number of BACE exercise classes are held at the Brookline Senior Center.
- BCOA sponsors special classes held at the Brookline Senior Center, such as the Matter of Balance class which focuses on the prevention of falls.
- The Brookline Recreation Department offers exercise and aquatic classes for older adults.
- The Rogerson Communities Fitness First Program, offered at the Brookline Senior Center, has a customized fitness program which uses Nautilus equipment.
- The Jewish Community Center in Newton has a gym and instructors who specialize in designing fitness programs for the elderly.
- Center Communities at 100 Center St. has its own gym which is open to non-residents.
- Hebrew Rehabilitation Center's day program has an exercise component.

11.15.4 Explore and promote the creation of other exercise programs. For example, Brookline Tai Chi received a Tufts Foundation grant to offer Tai Chi classes for seniors.

11.15.5 Publicize more widely the opportunity to join local walking groups and help support the creation of other walking group programs.

- The Brookline Senior Center has a Solemates Walking Group.
- FriendshipWorks has a Walking Buddies Program.
- Last year the Brookline Commission for Women held a program which discussed the benefits of exercise and encouraged the formation of neighborhood walking groups.

11.15.6 Explore the idea of having an Exercise Day Fair to connect people with resources.

Invite the organizations and groups that provide exercise for seniors. This would provide seniors with the opportunity to see all the possibilities that are available and to talk with program representatives. Neighborhood walking groups could also be organized at this event.

11.15.7 Publicize the availability of a home-based exercise program for seniors published by The National Institute on Aging entitled, "Your Everyday Guide" which is available in hard copy (Pub. # 09-4258, Jan. '09) and online at <www.nia.nih.gov/HealthInformation/Publications/Exercise Guide/>.

11.15.8 Look into developing a post-hospital follow-up program after home-based physical therapy has ended.

Following orthopedic surgery, people are either sent to a rehabilitation center where they work with physical therapists or they are discharged to their home and a physical therapist visits them for a specified period of time. After discharge from a rehabilitation center or after the specified physical therapy home visits have ended, people are left on their own to continue with their exercises. Some seniors might need a check-in service to keep up their motivation to continue with their exercise:

- A volunteer check-in program could be instituted to see how people are doing with their required exercise regimen.

- Occupational and physical therapy students from the local universities could be used as volunteers to encourage seniors to continue with their post-hospital exercise regimen.

11.16 HEARING IMPAIRMENT

When asked about major health problems that limited activities inside or outside the home, the second most frequently-mentioned health problem was hearing, mentioned by 49 percent of the respondents (the first most frequently mentioned problem was walking, mentioned by 61 percent). Hearing problems can affect personal safety, the ability to function independently, the ability to understand information, and the ability to interact socially with family and friends. People with a hearing impairment may avoid social occasions because they cannot tune out background noise in public settings.

The survey did not include questions about whether or not respondents had seen an MD, an audiologist, or a hearing aid specialist for their problem. Nor did it ask whether respondents were wearing hearing aids or had other assistive devices to compensate for their hearing loss. So we lack information that might help determine the level and type of services that might be needed by this group. However, the survey did indicate that those with hearing problems were:

- More likely than others to have difficulties using the telephone,
- More likely than others to have transportation problems,
- More likely than others to report that their social contact was "not enough."
- Slightly more likely than others to be depressed, and
- When asked whether there were any services that are not currently offered to Brookline residents that should be offered, one person mentioned the need for lip-reading classes.

However, there were no differences with regard to:

- Frequency of communication with relatives, friends, and neighbors,
- Whether people "often" felt lonely, and
- Frequency of activity participation

In spite of the fact that important information is lacking and the data present somewhat contradictory results about how well people manage with their hearing deficit, studies have shown that many hearing impaired are not receiving appropriate treatment or using devices that could be beneficial. Indeed, some people are not aware of the extent or seriousness of their hearing loss; they deny it; or they believe nothing can be done to help them. There are also strong negative attitudes about becoming hard of hearing. People often do not want to call attention to their hearing deficit by using hearing aids because it is a sign of aging or for cosmetic reasons. In addition, some people may have hearing aids but may not be using them because they were improperly fitted; they do not know how to adjust the hearing aid; or they have difficulty acclimating themselves to using it.

Having difficulty using the telephone is a potentially serious problem since people with severe hearing problems cannot talk with family and friends, arrange medical appointments, or get help in case of an emergency.

Recommendations[24]

11.16.1 There is a need for more public education about hearing loss and the treatments, devices, and services that can help. Technology in this field is growing rapidly (internet chatting, email, voice recognition systems using hand-held computers, fax machines, etc.)

11.16.2 People with hearing deficits should be encouraged to consider hearing aids as well as telephone amplifiers. (By law, all corded telephones are compatible with hearing aids.)

11.16.3 People need to be informed that equipment (hearing aids, telephone amplifiers, and signaling devices) may be available which is low-cost or free.

[24] For a detailed coverage of resources available for the hearing impaired see, Karen Rockow. 1997-2008. *The Savvy Consumer's Guide to Hearing Loss.* Developed under a contract from the Massachusetts Commission for the Deaf and Hard of Hearing.

For example, amplified phones, TTYs (text telephones), and signaling devices can be provided by the Massachusetts Equipment Distribution Program. Hear Now is an organization that also provides hearing aids to eligible people.

11.16.4 Classes in lip or speech reading should be offered since these can be beneficial for people with partial hearing loss.

Although some people may think the elderly are not able or willing to learn the speech reading technique, this skill should not be discounted since there may be some who might benefit.

11.16.5 Encourage people with a hearing deficit as well as their family members to participate in self-help or support programs..

Sharing feelings might help people overcome their sense of embarrassment as well as learn about coping strategies that have been successfully used by others. Support and self-help groups are available, such as the Boston Association for the Late-Deafened Adult (ALDA).

11.16.6 There is a need for more activism among agencies and professionals who have contact with the elderly. They need to be on the alert for those with a hearing impairment who do not use any hearing aids, telephone amplifiers, or signaling devices.

11.17 DEPRESSION

Studies have indicated that depression is one of the most common mental health problems of the elderly. In this study, 15 percent were depressed: 20 percent of the women compared with 3 percent of the men were depressed. People who were depressed tended to be disabled (either frail or severely disabled) and to report that their health was “fair” or “poor.” Thirty-two percent of the depressed reported that they reached out for help for their emotional problems, and, strikingly, 68 percent did not reach out.

Research has shown that late-onset depression is not a normal part of aging. More importantly, it is a treatable illness. There are a number of treatments for late-life depression that have been shown to be effective, such as psychotherapy, antidepressant medications, electroconvulsive therapy (ECT), and cognitive behavioral therapy. Depression is not always easy to recognize and, therefore, it can go unnoticed by doctors and other health or social service professionals. However, untreated depression can increase the severity of other diseases and lead to disability or even suicide.

There is a stigma attached to depression and to reaching out for help, and this stigma is stronger among the elderly than among younger people. The stigma can keep seniors from acknowledging to themselves as well as to others that they are depressed. Depression can be masked by feelings of being very tired or by other physical complaints, and individuals may feel there is no hope. In addition, they may be unwilling to ask for help because they are reluctant to take medications due to possible side effects or because of the cost.

The survey indicated that people who were depressed were more likely than others to worry about whether they were taking their medications correctly. Concerns about the proper dosage or timing of medications can be a serious problem since missing doses or taking more or less of the

medication can compromise treatment effectiveness. Sometimes patients may stop taking a new medication because they think it is not working, when, in reality, it may take 4 to 12 weeks before one can tell whether a medication or medications have had the desired effect.

Recommendations

11.17.1 Since survey results indicated that most people saw their physicians or other medical professionals during the year for check-ups or for illnesses, doctors and other health providers can be educated to be "first responders" in recognizing depression in older people.

This is easier said than done since medical appointments are often quite brief, focused on the problem at hand, and, thus, little time is allowed for other types of conversation.

11.17.2 Offer educational programs for older adults as well as caregivers to combat the stigma of depression and reaching out for help.

11.17.3 BCOA in conjunction with the Brookline Mental Health Center should continue to offer self- help groups which are appropriate for seniors who are suffering from depression.

Self-help groups provide many benefits. People can see that others have these feelings which might help them to feel less ashamed about their condition and be more willing to reach out for help.

11.17.4 BCOA should continue to work with the Massachusetts Association of Older Americans (MAOA) which has been focusing on the importance of mental health treatment for elders for over 20 years.

MAOA holds 4 or 5 conferences on mental health prevention and treatment each year.

11.17.5 BCOA should publicize and promote their pharmacy consultation program so that people can inquire about their medications.

People who are depressed and taking medications need to feel empowered about being advocates for themselves and asking questions about their medications. Since passivity may be a byproduct of depression, having this type of program available in the BCOA setting may be helpful.

11.17.6 Look into the various evidence-based programs that are available to combat depression and improve the mental health of seniors.

A May 2008 CDC Conference on Mental Health included a presentation entitled "Effective Programs to Treat Depression in Older Adults" [25] which gave examples of three evidence-based mental health programs that had been successfully used in communities: these were: (1) PEARLS (Program to Encourage Active Rewarding Lives for Seniors), (2) IMPACT (Improving

[25] http://www.cdc.gov/aging/pdf/mental_health_brief_2.pdf. Retrieved 8/21/10.

Mood-Promoting Access to Collaborative Treatment), and (3) Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors).

11.18 DENTAL CARE

Survey results indicate that people who were disabled (severely disabled and frail) were less likely to see a dentist during the past year than people who were not disabled (43 percent and 66 percent vs. 90 percent). People who had financial problems were also less likely to see a dentist during the past year than those who did not have financial problems (62 percent vs. 78 percent). Also, people with financial problems were more likely than others to say that tooth and mouth problems made it hard for them to eat (19 percent vs. 2 percent). Thus, disabled and low income people access dental care less regularly.

Research has shown that people with poor oral health are more likely to have cardiovascular disease, diabetes, and pneumonia. Thus, the consequences of poor dental health are far-reaching. Medicare does not cover basic oral health needs, and MassHealth makes it difficult for people to qualify for dental care if they have assets beyond $2,000 (for individuals) or $3,000 (for couples).

Recommendations

11.18.1 There is a need for more information about the reasons for this pattern.

Although the main reason appears to be cost, is this the only reason? Is transportation a problem? Do people think that seeing a dentist regularly is not worth the time, effort, and cost at this stage of their lives? Have they had a lifelong pattern of avoiding dentists?

11.18.2 Once more is known, continue to work with the Brookline Department of Public Health and local university dental schools to see if this issue can be addressed.

Information about lower cost dental school clinics is available in the Brookline Council on Aging Elder Resource Guide, vol. 5.

11.18.3 Keep abreast of actions being taken by the state government- sponsored working group on oral health.

In 2009, the Massachusetts Department of Public Health, Office of Oral Health did an oral health assessment of seniors 60 and over who lived either in long-term care facilities or received meals at state-subsidized meal sites. The results of this study, recently published in July 2010,[26] indicated that these seniors had poor dental health and needed improved access to dental care. The study recommended that a special working group be formed to address this problem. Among other actions suggested in this report, the working group is being encouraged to promote the training of doctors and nurses to perform oral health screenings during routine annual exams.

[26] Massachusetts Department of Public Health, Office of Oral Health . July 2010. The Commonwealth's High-Risk Senior Population: Results and Recommendations from a 2009 Statewide Oral Health Assessment.

11.19 MAJOR CONCERNS: QUESTIONS ABOUT HEALTH AND FINANCES

At the end of the survey, interviewers asked an open-ended question which elicited additional information from Brookline seniors. The question was, "*At present what are your most pressing concerns?"* The most pressing concerns related to health, mentioned by 23 percent, and finances, mentioned by 19 percent.

In addition to seniors mentioning specific health complaints, they had general concerns about their ability to remain healthy and their ability to care for themselves. People said such things as, *"I'm on a precarious plateau and I fear falling off the plateau"* and "*My eyesight is going. I am almost blind. I'm not sure what will happen when I can't see at all."* There were also concerns about not being a burden on others and the unpredictability of the future. People made comments like *"End of life care. I'd like to speak to someone about that," "Where will we end up?"* and *"I fear the unknown."*

Finances were a big concern not only from people with present financial problems, but from those who were able to handle their everyday finances. People were very concerned about outliving their finances, remarking, "*Will my money last for my lifetime*?" and *"I'm worried about the future…. that my money will run out."* These are not unrealistic concerns, but people rarely talk about them with family and friends.

Recommendations:

11.19.1 Continue to offer educational forums on advanced directives, healthcare proxies, and end-of-life planning.

11.19.2 Consider offering short-term support groups on end-of-life and aging concerns.

11.19.3 Provide information and educational forums on financial issues and how to choose a financial planner.

11.19.4 Offer ongoing direct assistance to help seniors apply for benefits.

11.20 IMPLEMENTATION OF RESEARCH RESULTS

This project was originally conceptualized as a study which utilized an action-research methodology. Not only did we wish to collect data about Brookline's 85+ residents, but we also wanted to refer seniors who had health and/or social service needs to the Brookline Council on Aging. In addition, we did not want this project to end with the publication of a research report; we wanted to develop a set of recommendations that would provide a blueprint for action steps that service providers could use to strengthen the service delivery system and that would improve the quality of life of Brookline seniors.

Recommendations

11.20.1 Form an implementation committee whose functions are to:

(1) Study and provide feedback about the recommendations,

(2) Prioritize and determine which recommendations are the most important and the most feasible and divide them into short- and long-term recommendations,

(3) Offer suggestions about the most effective strategies that can be used to implement the recommendations, and
(4) Monitor the implementation performance in the relevant areas.

11.20.2 The committee's composition should include people who represent the professions and organizations that provide services to the elderly as well as at least three representatives from the senior population who are members of the Board of the Brookline Council on Aging.

11.20.3 The committee should appoint someone who can lead, coordinate, and monitor the ongoing implementation efforts.

11.21 FURTHER RESEARCH

All respondents were randomly selected with the exception of public housing residents. Since we wanted a strong representation of public housing respondents, we attempted to contact 100% of those who were 85 or over to arrange for an interview. Only 14 public housing interviews were completed out of the eligible sample of 32, yielding a 44% response rate, slightly lower than the 51% response rate of the non- public housing residents.[27]

11.21.1 *Further research needs to be conducted with public housing residents to assess their needs. In addition, a different type of research methodology should be implemented with this group to obtain a higher response rate.*

11.21.2 Further research also needs to be conducted with residents who are non-English speakers to assess their needs. In particular, the interviews need to be translated into Chinese and Russian, and Chinese and Russian interviewers need to be trained to conduct these interviews.

[27] 80 public housing residents were on the original list.
Introductory letters to 15 residents were returned (residents had moved or were deceased).
Remainder = 65
33 respondents were excluded from the eligible sample for the following reasons:
2 said they were not 85
12 had language barriers
2 were ill
9 had no telephone or telephone was disconnected
7 were unable to be reached after 5 telephone calls
1 was mentally confused
32 were in the eligible sample after subtracting the 33 non-respondents.
14 interviews were completed
16 refusals
2 were contacted; reasons for non-response are unknown
14/32 = 44% response rate

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APPENDIX A

1 Interview Cover Sheet and Observations

2 Research Interview

3 Casefinding/Referral Form

Brookline Council on Aging

AGING AT HOME:
A STUDY OF BROOKLINE'S 85 & OLDER SENIORS

ID#: ☐☐☐☐☐

Interview Cover Sheet and Observations

1a. Respondent First Name: _____

1b. Respondent Last Name: _____

2. Respondent Study ID#: _____

3. Interviewer Name: _____

4a. First Interview Date: ____ / ____ / _____

4b. *(If interview not completed in one session)* Second Interview Date: ____ / ____ / _____

5a. Length of Time of 1st Interview: _____(minutes)

5b. *(If relevant))* Length of Time of 2nd Interview: _____(minutes)

6a. Type/ Location of 1st Interview:

- O Telephone interview
- O Respondent's home
- O Senior Center
- O Public Health Dept.
- O Public housing site
- O Center Communities site
- O 1415 Beacon Street
- O Other

_____

6b. *(If relevant))* Type/ Location of 2nd Interview:

- O Telephone interview
- O Respondent's home
- O Senior Center
- O Public Health Dept.
- O Public housing site
- O Center Communities site
- O 1415 Beacon Street
- O Other

_____

7. Type of Housing:
(Refer to separate housing list to determine if respondent lives in some type of senior or public housing)

- O Single family house (unattached)
- O Multiple family dwelling (2-3 family house)
- O Brookline Public Housing (senior housing)
- O Brookline Public Housing (non-senior housing)
- O Center Communities (senior housing)
- O Other Senior Housing
- O Apartment/condo that is not senior housing
- O Other

_____

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Interview Cover Sheet and Observations (cont.)

8a. Was interview completed?
O Yes O No

8b. (IF NO) Reasons for non-completion: O Respondent withdrew consent
O In interviewer's opinion, it was best not to continue because of:
_ Competency issues (dementia, confusion, other mental condition)
_ Physical illness
_ Language issues
_ Hearing problem
_ Other reason(s)?

9a. Was anyone else present during the interview?
O Yes O No O Don't Know

9b. (IF YES to 9a) Who? _____

9c. (IF YES to 9a) Did this person assist the respondent during the interview?
O Yes O No

9d. (IF YES to 9c) Why? _____

9e. (IF YES to 9c) What type of influence, if any, did this have on the interview?

_____

10a. Did the respondent have any type of mental condition (poor memory, senility, or confusion, etc.) physical problem (hearing), or language problems (not a native speaker) that made it difficult for him/her to answer the questions?
O Yes O No O Don't Know

10b. (IF YES) How, if at all, did this affect the interview?

_____

11a. Were there parts of the interview which seemed particularly difficult for the respondent - where s/he had difficulty answering the questions?
O Yes O No O Don't Know

11b. (IF YES) Please explain: _____

12a. Did you encounter any difficulties with the respondent during the course of the interview?
O Yes O No O Don't Know

12b. (IF YES) Please explain: _____

13. What was the easiest part of the telephone and interview process for you?

_____

_____

14. What was the most difficult part of the telephone and interview process for you?

_____

_____

ID#:

Brookline Council on Aging

AGING AT HOME:

A STUDY OF BROOKLINE'S

85 & OLDER SENIORS

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THESE FIRST QUESTIONS ASK ABOUT YOUR HOUSING SITUATION.

1. How long have you lived in Brookline? Have you lived there:
   - O 1 yr. or less
   - O More than 1 yr. to 5 yrs.
   - O More than 5 yrs. to 10 yrs.
   - O More than 10 yrs.
   - O Don't Know(DK)
   - O No Response(NR)

2. Do you own or rent your home?
   - O Own
   - O Rent
   - O Other _____

3. What type of house is it? *(Choose one)*
   Do you live in a:
   - O Single family house (unattached)
   - O Multiple family dwelling (2-3 family house)
   - O Apartment/condo
   - O Other _____
   - O No Response

4a. Do other people live with you?
   O Yes O No

4b. (IF YES) Who lives with you? *(Check all that apply)*
   - O Spouse or partner
   - O Other relative
   - O Non-relative
   - O Paid live-in companion

5. Do you have a dog or a cat?
   O Yes O No O NR

6. Are you giving serious thought to moving from your present residence within the next two years?
   O Yes O No O DK O NR

7. Do you use a cane, walker, wheelchair or scooter to help you get around inside or outside your home?
   O Yes O No O NR

8a. During the past year, have you fallen?
   O Yes O No O NR

8b. (IF YES) Did you fall:
   - O Inside your home
   - O Outside your home
   - O In both places

8c. (IF YES) Did you experience an injury as a result of your fall?
   O Yes O No O NR

SOME RESIDENCES HAVE SPECIAL FEATURES TO ASSIST PERSONS WHO HAVE PHYSICAL IMPAIRMENTS OR HEALTH PROBLEMS.

9. Do you have an emergency call system so you can get help when needed? This is a system you use to call someone to come if you fall or need help. It can be worn around your neck, attached to a wall, or placed on a piece of furniture.
   O Yes O No O NR

10. Does your home have special features to safeguard older or disabled persons, such as a seat in your shower or tub, grab bars around the toilet, or a raised toilet seat?
   O Yes O No O NR

11. Does your home have any special features that make it easier for you to get around, such as wider doorways or hallways, ramps leading to a street level entrance, railings, easy to open doors, accessible parking or drop-off site, special kitchen features, an elevator or chair lift?
   O Yes O No O NR

12a. Does your home have a smoke detector?
   O Yes O No O NR

12b. Does your home have a carbon monoxide detector?
   O Yes O No O NR

12c. (IF YES to Q12a or Q12b) Have the batteries in these detectors been changed within the past year?
   O Yes O No O DK O NR

13. In thinking about your neighborhood, do you have concerns about your physical safety because of crime?
   O Yes O No O DK O NR

THESE NEXT QUESTIONS ASK ABOUT TRANSPORTATION.

1a. Do you currently drive a car? (IF NO, SKIP TO Q2)
   O Yes O No O NR

1b. (IF YES) How frequently do you drive? Do you drive:
   - O Everyday or almost everyday
   - O Once or twice a week
   - O Less than once a week

1c. (IF YES) Do you limit your driving for any reason? For example, some people say they don't like to drive at night, on highways, in bad weather, or for long distances.
   O Yes O No O DK O NR

2. Whether people drive or not, they may also use other types of transportation. I'm going to read a list and you can tell me which types you use.

	Yes	No	Unfamiliar with this
a. Family, friends or neighbors	O	O	O
b. Regular taxi	O	O	O
c. Public transportation (bus, MBTA)	O	O	O
d. Brookline Senior Center Van	O	O	O
e. Elderbus	O	O	O
f. Brookline Elder Taxi System (BETS)	O	O	O
g. "The Ride" (MBTA)	O	O	O
h. H.E.L.P. Program Escorts (Home and Escort Linkage Program)	O	O	O
i. Center Communities van	O	O	O
j. Busy Bee Transportation (Springwell)	O	O	O
k. Electric scooter for outdoor use	O	O	O
l. Other? (Please specify):	O	O	O

3. With respect to transportation:
   a. Do you have a problem finding people who can act as escorts?
      O Yes O No
   b. Are there other problems?
      O Yes O No

   (IF YES to Q3b) What are they?:

NOW I'D LIKE TO ASK ABOUT YOUR FAMILY, FRIENDS, AND NEIGHBORS.

1. Do you have family members who live nearby? (e.g., less than 30 minutes away)?
   O Yes O No O NR

2. **During the past month**, how frequently did you talk with family members, friends, or neighbors either in person or by telephone? Was it:
   O Less than once a week
   O Once or twice a week
   O Three to five times a week
   O Almost every day
   O Uncertain
   O NR

3. Would you say your social contact with family members, friends or neighbors was:
   O Not enough
   O Enough
   O Too much
   O DK
   O NR

4. Do you have a computer which you use to keep in touch with family or friends?
   O Yes O No O NR

5a. Do you have someone to talk to if you have a problem or if you have an important decision to make?
   O Yes O No O DK O NR

5b. (IF YES) Who is it? Is it a:	Yes	No
a. Relative	O	O
b. Friend or neighbor	O	O
c. Volunteer	O	O
d. Health professional (doctor, social worker nurse, etc.)	O	O
e. Some other person (Please specify):	O	O

6. Do you have a formal or informal system set up where someone checks up on you or you check up on someone else?
   O Yes O No O DK O NR

7a. Are you currently assisting or arranging services for someone who is sick or disabled and cannot care for himself or herself?
   O Yes O No O NR

   (IF NO, CONTINUE TO Q1a, COMMUNITY ACTIVITIES)

7b. (IF YES to Q7a) Who are you caring for?	Yes	No
a. Spouse or partner	O	O
b. Other relative	O	O
c. Friend/neighbor	O	O

7c. (IF YES to Q7a) Are you caring for this person in your home?
   O Yes O No O NR

7d. (IF YES to Q7a) Is anyone helping you with your caretaking activities?
   O Yes O No O NR

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THIS NEXT SECTION ASKS ABOUT YOUR COMMUNITY ACTIVITIES.

1a. Generally, when weather is not an issue, do you take part in activities such as visiting relatives or friends, attending religious services or activities, volunteering, going to movies, concerts, or restaurants, etc.?
O Yes O No O NR

1b. (IF YES) How often do you participate in these activities? Would you say:
O Less than once a week
O Once or twice a week
O Three to five times a week
O Almost every day
O Uncertain
O NR

2. Do you receive the Brookline Senior Center/ Council on Aging newsletter?
O Yes O No O DK O NR

3. During the past month, have you participated in any Brookline Senior Center activities?
O Yes O No O DK O NR

4. Do you currently do any type of volunteering for an organization?
O Yes O No O NR

5. Did you get to vote in the presidential election this past November?
O Yes O No O NR

I WANT TO ASK YOU SOME QUESTIONS ABOUT YOUR HEALTH.

1. How would you rate your health in the past month? Would you say it's excellent, very good, good, fair, or poor?
O Excellent
O Very good
O Good
O Fair
O Poor
O DK
O NR

During the past year did you see any of the following:

2. A doctor or other health care provider (for example, a nurse practitioner, or physician's assistant) for any reason including for a check-up or because you were ill?
O Yes O No O NR

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3. A health provider to get a flu shot?
O Yes O No O NR

4. A dentist for check-ups or because you had a problem?
O Yes O No O NR

5. An ophthalmologist or an optometrist for an eye exam or because you had a vision problem?
O Yes O No O NR

6. A podiatrist/ a foot doctor?
O Yes O No O NR

7. A chiropractor, acupuncturist, or a homeopath?
O Yes O No O NR

8a. **During the past year** did you use services for any problems such as anxiety or depression, or family conflicts, or alcohol use?
O Yes O No O NR

8b. (IF YES to Q8a) Did you see or visit a:

	Yes	No
1. Doctor	O	O
2. Psychiatrist/psychologist	O	O
3. Social worker/ counselor	O	O
4. Clergy	O	O
5. Support group	O	O
6. Someone else?	O	O

(IF YES to Q8b.6) Whom did you see?

9. **During the past year** did you receive services from a:

	Yes	No
a. Visiting nurse	O	O
b. Home health aide or homemaker	O	O
c. Companion or live-in	O	O
d. Friendly visitor	O	O
e. Someone else?	O	O

(IF YES to Q9e) Whom did you see?

10. Do you currently smoke?
O Yes O No O NR

11. Do you currently engage in a physical activity such as walking, dancing, or yoga for at least half an hour for three or more times a week?
O Yes O No O NR

THESE NEXT QUESTIONS ASK ABOUT HEALTH PROBLEMS THAT MAY LIMIT ACTIVITIES.

12a. Are you **limited** in your activities either inside your home or when you go outside because of any physical condition or health problem?

O Yes O No O DK O NR

12b. (IF YES) What are the major health problems that **limit** your activities inside your home or when you go outside? I'm going to read a list and you can tell me which, if any, health problems **limit** your activities.

	Yes	No
1. Arthritis/rheumatism	O	O
2. Back or neck problem	O	O
3. Fractures, bone/joint injury	O	O
4. Walking problem	O	O
5. Lung/breathing problem	O	O
6. Hearing problem	O	O
7. Eye/vision problem	O	O
8. Heart disease	O	O
9. Stroke	O	O
10. Hypertension/high blood pressure	O	O
11. Diabetes	O	O
12. Cancer	O	O
13. Depression/anxiety/emotional problem	O	O
14. Other impairment/ other problem?	O	O

(IF YES to 12b.14) Please explain:

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13. Now, I'm going to read a list of common daily activities, and I want to know if you have difficulty doing them **on your own, without assistance from other people**. **During the past month**, have you had difficulty with:

	Yes	No
a. Bathing or Showering	O	O
b. Dressing	O	O
c. Toileting	O	O
d. Getting in or out of your bed or a chair	O	O
e. Eating	O	O
f. Walking across a room	O	O
g. Using the phone	O	O
h. Doing housework	O	O
i. Taking medications	O	O
j. Preparing hot meals	O	O
k. Shopping for groceries	O	O
l. Managing money (paying bills, etc.)	O	O
m. Doing laundry	O	O
o. Any other tasks?	O	O

(IF YES to Q13o) Please describe these tasks:

14a. (IF HAS DIFFICULTY DOING ONE OR MORE ACTIVITIES ON OWN) Are you currently receiving assistance with this activity /these activities from anyone?

O Yes O No O NR

14b. (IF YES to Q14a) Who is helping you? Is it a:

	Yes	No
1. Relative	O	O
2. Friend or neighbor	O	O
3. Volunteer	O	O
4. Home health aide, homemaker, companion, or a live-in companion	O	O
5. Anyone else?	O	O

(IF YES to Q14b.5) Whom did you see?

IN THINKING ABOUT YOUR EATING HABITS DURING THE PAST MONTH, DO YOU:

15. Eat fewer than two meals per day?
O Yes O No

16. Have tooth or mouth problems that make it hard to eat?
O Yes O No

17. Think you've lost weight without trying?
O Yes O No

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18. Think you've been eating poorly because of a decreased appetite?
O Yes O No

19. Think you have gained weight?
O Yes O No

20. Have other concerns about eating?
O Yes O No

(IF YES to Q20) What are your other concerns?

21. Do you regularly get Meals on Wheels or get lunch or dinner provided in a group setting such as the Brookline Senior Center or a senior housing residence?
a. Meals on Wheels
O Yes O No
b. Lunch or dinner in a group setting (e.g., Senior Center, senior housing)
O Yes O No

22. Are you taking medications on a regular basis?
O Yes O No

(IF NO to Q22, SKIP TO Q 27)

(IF YES to Q22, ANSWER Q 23-26))

	Yes	No
23. Do you wonder whether you're taking them correctly?	O	O
24. Do you worry about side effects or drug interactions?	O	O
25. Do you sometimes forget to take your medications?	O	O
26. Any other concerns about medications?	O	O

(IF YES to Q26) What are your other concerns?

27. Were there times during the past month when you **often** experienced any of the following feelings?
Were there times when you **often**:

	Yes	No	NR
a. Felt depressed	O	O	O
b. Felt everything you did was an effort	O	O	O
c. Felt your sleep was restless	O	O	O
d. Felt happy	O	O	O
e. Felt lonely	O	O	O
f. Enjoyed life	O	O	O
g. Felt sad	O	O	O
h. Felt you could not get going	O	O	O
i. Had a lot of trouble remembering things	O	O	O

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NOW I HAVE SOME QUESTIONS ABOUT YOUR FINANCES.

1. At present, how well does the amount of money you have take care of your needs? *(Choose one)*
O 1-Are your expenses no problem for you?
O 2-Can you barely meet your expenses?
O 3-Are your expenses so heavy that you cannot meet the payments?

2.

Are you having difficulties paying for:

	Yes	No	NR
a. Heat	O	O	O
b. Electricity	O	O	O
c. Rent or mortgage	O	O	O
d. Property taxes	O	O	O
e. Food	O	O	O
f. Homemaker, home health aide, companion, live-in companion	O	O	O
g. Health care, dental care, health insurance	O	O	O
h. Medications	O	O	O
i. Car expenses (gas, repairs, auto insurance)	O	O	O
j. Payments for transportation such as The Ride, Taxis, etc.?	O	O	O
k. Are you having difficulties paying income taxes (this does not include filling out tax forms)	O	O	O
l. Are there **other** areas in which you are having difficulties?	O	O	O

(IF YES to Q2l) What are these other areas?

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THESE QUESTIONS ASK FOR GENERAL INFORMATION ABOUT YOURSELF.

1. What is your current marital status?
   - O Married
   - O Widowed
   - O Divorced/Separated
   - O Partner
   - O Never Married
   - O NR

2. Do you have any children?
   O Yes O No O NR

3a. Were you born in the United States or in another country?
   - O United States
   - O Another country (Specify): _____
   - O NR

3b. (IF ANOTHER COUNTRY) How long have you lived in the U.S.?
   - O Less than 1 year
   - O More than 1 to 3 years
   - O More than 3 to 5 years
   - O More than 5 to 10 years
   - O More than 10 years
   - O NR

4. Are you currently working in paid employment?
   O Yes O No O NR

5. How old are you?
   - O 85 to 89
   - O 90 to 94
   - O 95+
   - O NR

6. Sex (noted by interviewer)
   - O Male
   - O Female
   - O NR

7. What racial or ethnic group do you identify with? *(Check all that apply)*
   - O White or Caucasian
   - O Asian
   - O Black or African American
   - O Hispanic
   - O American Indian/Alaskan Native
   - O Other _____
   - O NR

8. What is the highest year of schooling that you completed?
   - O No formal education
   - O Less than 9th grade
   - O Some high school, no diploma
   - O High school grad
   - O Some college (including Jr. College)
   - O Bachelor's degree
   - O Graduate or professional training
   - O NR

9. What is your religious affiliation?
   - O Protestant
   - O Catholic
   - O Jewish
   - O Buddhist
   - O Muslim
   - O Other _____
   - O None
   - O NR

10a. All things considered, how satisfied are you with your life these days?
   - O Very satisfied
   - O Somewhat satisfied
   - O Not very satisfied
   - O Not at all satisfied
   - O DK
   - O NR

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10b. (IF NOT VERY OR NOT AT ALL SATISFIED) Can you tell me why you say that?

11a. At present, what is or what are your most pressing concerns?

11b. Anything else?

11c. Anything else?

12a. Are there some services or activities that are not currently available to Brookline residents that you think should be offered?
O Yes O No O DK O NR

12b. (IF YES) What are they?

12c. Anything else?

12d. Anything else?

Interviewer: Go to the Service Needs/Interviewer Observation Form

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Brookline Council on Aging

AGING AT HOME:
A STUDY OF BROOKLINE'S 85 and OLDER SENIORS
Case-Finding Form

ID#: ☐☐☐☐☐

Respondent First Name: _____

Respondent Last Name: _____

Respondent Study ID#: _____

Interviewer Name: _____

Interview Date: ____ / ____ / _____

I'VE ASKED A LOT OF QUESTIONS AND GATHERED INFORMATION THAT WILL BE HELPFUL AS WE PLAN FOR THE FUTURE. NOW, I'D LIKE TO FIND OUT IF THERE ARE ANY SERVICES OR ANY INFORMATION THAT YOU NEED.

HOUSING	YES	NO	DK/NR
1. Would you like information: a. About different housing alternatives such as assisted living or other types of senior housing?	O	O	O
b. About public subsidized housing?	O	O	O
2. Does your home need any repairs or modifications such as handrails, grab bars, ramps, etc.?	O	O	O
3. Would you like someone to come to your home to review the safety features to help prevent falls?	O	O	O
4. Are you interested in learning about a Personal Emergency Response System?	O	O	O
5. (IF HAS HOME WITH YARD) Would you like assistance with yard work or snow shoveling?	O	O	O
6. Would you like someone to come to your home to help you get rid of furniture or other items you no longer need?	O	O	O
7. (IF RELEVANT) Would you like someone to help you develop a plan for moving into a smaller home?	O	O	O
8. If you have concerns about crime and your personal safety in your neighborhood, would you like to speak to someone about this?	O	O	O

TRANSPORTATION	YES	NO	DK/NR
9. (IF RESPONDENT DRIVES) Would you like to talk to someone about driving safety concerns?	O	O	O
10. (IF RESPONDENT DRIVES) Programs are available that assess driving skills. Would this type of program be of interest to you?	O	O	O
11. Would you like information about the different types of transportation options that are available?	O	O	O
12. Would you like information about how to apply for transportation services?	O	O	O
13. Do you need transportation to places that are important to you, such as medical appointments?	O	O	O

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SOCIAL ACTIVITIES/ SOCIAL SUPPORT	YES	NO	DK/NR
14. Would you like to talk to someone about any family problems you might be having?	O	O	O
15. Would you like information about activities that would increase your contact with other people?	O	O	O
16. Would you be interested in receiving telephone assurance calls or having a friendly visitor come to your home?	O	O	O
17. (IF RESPONDENT IS A CARE GIVER) Would you like to talk to someone about services that are available to help people who are caring for others?	O	O	O
18. (IF RESPONDENT HAS PETS) Do you need any assistance with your pets?	O	O	O
19. If you don't receive the Brookline Senior Center newsletter, would you like to receive it?	O	O	O
20. Would you like information about social activities such as Senior Center programs, volunteer activities, educational programs, or activities at your place of worship?	O	O	O
21. Would you like information about large print books or recorded books that are available through the Brookline Library?	O	O	O

FUNCTIONAL ABILITIES If no one is currently helping you, do you need assistance with:	YES	NO	DK/NR
22. Bathing, or dressing?	O	O	O
23. Shopping for groceries?	O	O	O
24. Housework or laundry?	O	O	O
25. Meal preparation?	O	O	O
26. Would you like to speak to someone about Meals on Wheels?	O	O	O

HEALTH	YES	NO	DK/NR
27. If you don't have a regular health care provider and/or don't know where to go for treatment, would you like to speak to someone who could help you with this?	O	O	O
Would you like to speak to someone about: 28. Your health plan coverage?	O	O	O
29. The cost of your health plan?	O	O	O
30. The cost of your medications?	O	O	O
31. Other health concerns (physical, dental, visual, etc.)?	O	O	O
32. Would you like to talk to someone about your diet and eating habits?	O	O	O
33. Would you like to speak to someone about any concerns you may have about the medications you are taking?	O	O	O
34. Do you need assistance taking your medications or need to be reminded to take your medications?	O	O	O
35. Do you need help understanding your medical insurance coverage for medications?	O	O	O
36. If you've been feeling sad, or lonely, or lack interest in your daily activities, would you like to speak to someone about these feelings?	O	O	O
37. If you've been bothered because you have trouble remembering things, would you like to speak to someone about this?	O	O	O
38. If you smoke or use alcohol, would you like to talk to someone about your smoking or alcohol use?	O	O	O

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FINANCIAL/ LEGAL CONCERNS

Would you like to talk to someone:	YES	NO	DK/NR
39. About money management - keeping track of money and bills, and paying bills?	O	O	O
40. About applying for financial assistance (i.e., food stamps, SSI, or fuel assistance)?	O	O	O
41. About any other financial concerns?	O	O	O
42. If you think someone is taking advantage of you or your money, would you like to speak to someone about this?	O	O	O
43. Would you like to speak to a lawyer about any legal problems you may be having?	O	O	O

44. Is there an issue we might have missed that you need help with? O Yes O No

(IF YES) What is it?

_____

_____

_____

45. If you need information or assistance with any of the areas we've covered, would you be willing to have someone from the Council on Aging contact you to provide you with information, see which services you need, and refer you to the appropriate resources?

O Yes O No O Don't Know-Will have to think it over.

(IF YES) Some from the Brookline Council on Aging will contact you.

(IF NO) Can I call you back to see if you have changed your mind? O Yes O No

(IF DON'T KNOW) Can I call you back to see if you have made up your mind? O Yes O No

46. Do you have any other comments you'd like to share with us?

_____

_____

_____

47. Do you have any questions about this study or about how the data will be used?

_____

_____

_____

Thank you so much for spending this time with me. The information you've provided will help us plan services for the senior population, and we'll be sure to send you a summary of the key findings.

If you have questions about anything we've discussed today, please contact Dr. Alberta Lipson. I'll give you her contact information. Her phone number is (617) 730-2333.

Interview Ends

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FOR THE INTERVIEWER TO COMMENT:

1. Does the respondent have **urgent** concerns that require immediate attention?
   O Yes O No O Don't Know

   (IF YES) Please explain.

   (IF YES) What action did you take?

   (If you are unsure, but have a concern, it is still important that you tell us about it.) **Please refer to Case-Finding Guidelines.**

2. Did you identify any respondent needs during the course of the interview that the respondent did not identify him/herself on the Case-Finding form?
   O Yes O No

   (IF YES) Please explain.

PLEASE MAIL THE CASE-FINDING FORM INTO THE BCOA OFFICE AS SOON AS YOU CAN. USE THE PREPARED ENVELOPE.

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Appendix B

TOWN OF BROOKLINE
Massachusetts

Council on Aging
85 and Over Project

At Brookline Senior Center

RUTHANN DOBEK, LICSW
DIRECTOR, CO-INVESTIGATOR

ALBERTA LIPSON, PH.D.
RESEARCHER, CO-INVESTIGATOR

93 Winchester St.
Brookline, MA 02446
617-730-2777
Fax: 617-730-2761

www.townofbrooklinemass.com

March , 2009

Dear "Person's Name",

Within a week or so, an interviewer from the Brookline Council on Aging will be calling you to invite you to participate in a research project about Brookline's seniors. We're undertaking this study because the 85 and older group is the fastest growing age group in the country. Community service providers need to better understand how Brookline's seniors are doing and what the community can do to improve services. We are fortunate to have received a grant from the Brookline Community Foundation to undertake this project and to receive support from the Brookline Public Health Department.

People will be interviewed either in person or on the telephone. The interview will take approximately 45 minutes and will cover areas such as transportation, housing, and health. People will also be asked if they would like additional information or assistance with specific issues. All information will be kept confidential. Personal contact information will only be used so the Council on Aging can follow up on requests for information or services. Participation is completely voluntary. People may decline to answer any specific questions and they may stop the interview at any time. In reports that may result from this project, participants will remain anonymous and data will be presented only in summary form.

Your help and that of the others being asked to participate is essential to this study's success and we greatly appreciate any assistance you can give us. If you have questions, please don't hesitate to call us at

Sincerely,

Ruthann Dobek , LICSW
Director and Co-investigator
85 and Over Population

Alberta Lipson, Ph.D.
Researcher and Co-investigator,
85 and Over Population

APPENDIX C

BROOKLINE COUNCIL ON AGING (BCOA)
85 and OVER STUDY

CASE-FINDING GUIDELINES

In the course of conducting an interview, whether in-person or on the telephone, you may sometimes come across situations when you should call 911 or a social worker from the Brookline Council on Aging. These guidelines are designed to help you decide what to do when you come across a situation where some type of action on your part is needed. We have developed 4 different levels of action in addition to filling out the Service Needs/Interviewer Observation Form and mailing it to the BCOA. **Remember, when in doubt, call BCOA.**

Level 1 -- Call 911 first and then an intake BCOA social worker (617-730-2777).

1. The person appears incoherent, or has fallen, or is bruised and probably needs hospitalization.
2. There appears to be evidence of elder abuse.

You feel that this is an emergency. The situation needs immediate attention.

Level 2 – Call Sue Welpton at 617-730-2755 or ask for an available social worker (617-730-2777).

1. The person appears depressed, or disheveled, or confused, or has a dirty home.
2. The person thinks someone is taking advantage of them or their money.

You feel that person should have help right away. You are worried about them. You want to discuss the case with a trained professional.

Level 3 – Call an intake BCOA social worker (617-730-2777).

1. The person is lonely, or slightly confused, or the home is disorganized.
2. The person says they are fine and do not need anything, but wants you to stay longer or keeps asking you questions.

You think they need more services than they are currently getting. This situation does not require immediate attention, but you sense they need help.

Level 4 – This level does not require immediate action.

1. The person requires some information and/or assistance in areas noted on the Service Needs/Interviewer Observation Form.

You have told the person that more information is forthcoming from the Council on Aging. You have either given the person the BCOA Elder Resource Brook Vol. 5, or have told him/her that they will receive it in the mail.

Appendix D1 Comparison Between 85+ Sample and Total Brookline Population

	85+ Sample (2009)		Total Brookline Population (2006-08)	
	85+ Sample	%	N	%
TOTAL	*223*	100%	*62,255*	100%
TOTAL 85+			*1,282*	*2.1% of Brookline pop.*
TOTAL 65+			*7,320*	*12% of Brookline pop.*
SEX			*65+*	
Female	158	71%	4,152	57%
Male	65	29%	3,168	43%
Total	*223*		*7,320*	
EDUCATION			*People 25 years and older*	
Less than 9th grade	5	2%	670	2%
Some high school	6	3%	577	1%
High school graduate	53	24%	3,016	7%
Some college (including jr. college)	34	15%	6,289	12%
Bachelor's degree	56	25%	13,498	31%
Graduate or professional training	67	30%	20,295	47%
Total	*221*		*43,119*	
RACIAL/ETHNIC GROUP			*One race*	
White/Caucasian	213	96%	49,449	79%
Other	9	4%	11,616	21%
Total	*222*		*61,065*	
BORN IN UNITED STATES				
Yes	180	81%	45,716	75%
No	41	19%	16,539	25%
Total	*221*		*62,255*	
HOUSING TENURE				
Occupied housing units				
Owner-occupied	97	45%	13,952	53%
Renter-occupied	119	55%	12,449	47%
	216		*26,401*	
LIVING GROUP ARRANGEMENTS				
Lives alone	129	58%	8,349	32%
Lives with spouse	59	26%	11,680	44%
Lives with other relative	14	6%	2,620	10%
Lives with non-relative or paid companion	21	9%	3.752	14%
	223		*26,401*	

Total Brookline Population Statistics from: American FactFinder. U.S. Census breau. Brookline town, Norfolk Massachusetts, Data Set: 2006-2008 American Community survey 3-Year Estimates: Survey American Community Survey. www.factfinder.census.gov.

APPENDIX D2 SOCIAL DEMOGRAPHIC CHARACTERISTICS: Sample Compared to Census 2000 Data

	BCOA 85+ Sample		U.S. Census Bureau, 2000, 85+ Data
	N	%	
SEX			
Female	158	71%	71%
Male	65	29%	29%
Total	*223*		
MARITAL STATUS			
Married	58	26%	31%
Widowed	125	56%	61%
Divorced/Separated	13	6%	3%
Partner	3	1%	-
Never Married	24	11%	5%
Total	*223*		
EDUCATION			
Less than 9th grade	5	2%	
Some high school	6	3%	47% (less than hs graduate)
High school graduate	53	24%	27%
Some college (including jr. college)	34	15%	14%
Bachelor's degree	56	25%	13% (bachelor's degree or more)
Graduate or professional training	67	30%	
Total	*221*		
BORN IN UNITED STATES			
Yes	180	81%	90%
No	41	19%	10%
Total	*221*		
CURRENTLY EMPLOYED			
Yes	17	8%	7%
No	204	92%	93%
Total	*221*		
HOME OWNERSHIP			
Yes	97	45%	65%
No	119	55%	35%

U.S. Census 2000, Special Reports. "We the People: Aging in the United States." Issued December 2004. www.census.gov/prod/2004pubs/censr-19.pdf

APPENDIX E

COMMENTS and SUGGESTIONS OFFERED BY RESPONDENTS

The following comments were offered by respondents when asked "*Are there some services or activities that are not currently available to Brookline residents that you think should be offered?*

Program for new community members

"Welcome Wagon" for new members of the community, especially senior citizens to welcome them and discuss town services."

Police

"More police needed on the streets."

"Police need to enforce traffic rules for pedestrians who ignore traffic signals – especially the elderly."

Aging in Place Services

"Interested in a program similar to the Beacon Hill project in which people pay for membership and are entitled to easy access to a variety of services."

"Would like a Beacon Hill Village type of service for at home elders."

"Would like more home services so people can age in their home."

Mixed-Age Housing

"I live in senior housing residence. Would like Brookline to have more of an age-mix in housing."

Affordable Snow Shoveling

"Need affordable snow shoveling for seniors."

"Trying to get someone to shovel snow."

"Would like to be able to hire local kids to help with snow shoveling between plowings."

Home Repairs

"Need someplace where you can call to get house repairs like when the roof needs fixing."

More Opportunities to Socialize

"All new buildings (residences) should have a community room for elderly residents to gather and meet one another. Should be a requirement for new buildings."

Transportation

"There are no phone for cabs at high school."

"Many activities are offered in Brookline, but it's not always easy to take advantage of them because of the lack of escort services."

Adult Education

"There are too many classes at night."

Neighborhood Concerns

"Neighborhood is in disrepair. Broken down area, pot holes, shabby…. Sidewalks in neighborhood rough and uneven – difficult for walkers – need repair."

"Neighborhood not well-kept."

Taxes

"Brookline taxes are exorbitant."

Other

"Charge too much for seniors at the public golf club."

Senior Center

"Would like to attend lip-reading class since is very hard of hearing."

"Need more activities for higher functioning elders, plus the transportation involved. It would be better if suitable programs at the Senor Center could be offered for more than just one hour, perhaps ½ day."

"I attended the Senior Center a few times and thought the participants were too old."

"Need activities with a higher intellectual level."

"Would like Senior Center to hold more political/current events classes."

"Want classes in knitting and crocheting."

"I never heard of Senior Center before you came to see me."

"I miss my friends who are no longer here but I'm grateful for the senior center activities which I go to five times a week.

"I'd like volunteers to read to me."

"In planning activities for the elderly, they should not be treated like babies."

In addition to the above, some respondents voluntarily offered the following comments about Brookline

"Brookline is a good place to live."

"There are good facilities in Brookline. More here than I've ever seen."

"There are many services and activities offered."

"Brookline is a wonderful community. It is manageable. The library is wonderful."

"I feel fortunate that Brookline has services for seniors, although I haven't felt the need to use them very much."

"Grateful that we live in Brookline."

"Brookline is really giving good care to seniors. In future I may need help but right now I'm o.k."

"Brookline wonderful place to live – cares about the elderly."

"Appreciate town resources and concern."

"Brookline has been very attentive to the needs of the community."

"The town does very well to provide all kinds of services."